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RESPIRATORY DISEASES*

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In my preparation of the paper on the treatment of respiratory diseases, I shall confine my remarks to the treatment of influenza and pneumonia, the two most frequent respiratory diseases.

The fact that there is no specific treatment for respiratory diseases, such as influenza and pneumonia, was forcibly impressed upon the medical profession soon after the outbreak of the influenza epidemic during the world war. The results, of course, naturally were that each physician devised plans of treatment which he applied on the spur of the moment, under stress of necessity, and judged the efficiency of his methods of treatment by the results obtained. So numerous and varied were the treatments that the patent medicine manufacturers and quack remedy inventors reaped an enormous harvest from the suffering public, through their advertisements of cures broadcasted in the newspapers, until the A. M. A., through the journal, issued a denial of any cure, and the United States Public Health service issued a bulletin to the same effect. Therefore, the medical treatment of these respiratory infections followed somewhat after the age-old custom, that the less there is known of a disease the more treatment there is for it.

It makes little difference with the patient or with the family of the patient whether the pneumonia is a bronchopneumonia or a lobar pneumonia, whether it is of a primary or of a secondary type, whether it is due to the pneumococci, streptococci or any other organism, or a pneumonia following a surgical procedure. All the patient and family want is for the patient to get well as quickly as possible.

In the treatment of influenza and pneumonia every physician is apt to have a line of treatment which he prefers to follow. It may be serum therapy, camphor injection, creosote medication, cold fresh air with little or no medicine, or heat in some form applied locally to the chest, or a combination of these methods. Not all of these methods can be followed, nor do I think any of them devoid of merit. In fact all are based on sound therapeutic principles and are used with success, but the very indiscriminate nature of this sort of treatment, even though for the most part good and useful, leads one to infer that all methods cannot be of equal value, so the fewer the medicines the greater will be the number of cures, would seem to be especially applicable in the treatment of influenza.

The methods of treatment usually followed as a routine by myself will be given without much comment, except that I have tried to limit my treatment to as few drugs as possible. Attention should be given to prevent the spread of the disease by such ordinary measures as burning and disposal of the sputum, giving proper instructions as to heating and ventilating the sick room, and above all, in my judgment, the importance of rest in bed until all symptoms have disappeared. I usually begin medication by giving six or eight doses of calomel and soda followed with saline laxative, and a capsule containing aspirin, 5 grains, Dovers powder, 3 grains, pulv-camphor, 1-2 grain, every two hours, and, I believe the mixed vaccines are useful, if given early. But in the matter of preventing the extension of the infection to other parts of the lungs, I believe heat is the best measure we have, and heat in the lung itself, if possible. Hot water bottles, electric pads and the old home-made mustard plaster applied to the chest we have found very useful. The mustard plaster should cover the entire chest and should remain on until the skin turns red, then remove and re-apply every six or eight hours. Diathermic heat, where it can be applied, is by far the best form of heat to the lungs, as it is generated in the lung itself. Shortly after the diathermic is begun the

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patient will voluntarily state that he feels better and it will be noticeable that the patient is more comfortable, if there is any cyanosis it will improve, respiration will be easier and free from the characteristic grunt, the temperature curve will descend, the pulse will become more normal, and within a few hours the patient presents a picture of confidence and ease.

Diathermic heat is not a specific in the treatment of pneumonia and influenza, but it is a distinct and valuable aid, and its failure to be followed early by note-worthy and symptomatic relief indicates an unfavorable prognosis. Iodine administered intravenously in ten minims doses and given in 10 c.c. distilled water is claimed by a number of authorities to be almost a specific in influenza. In a report of a series of 500 cases treated by the iodine intravenously at one of the large American hospitals, most of the cases were greatly benefitted by the first injection, some of the more serious cases required the second and a few even the third injection, while one case, the most serious of all, was given five injections. I mention this iodine treatment for the reason that it strikes me as being a good one and would like to know if any of the doctors present have used this method, and if so, with what results. In view of the fact that we are entirely at a loss to designate any microorganism as the cause of influenza, we are forced to follow the time-honored procedure of symptomatic treatment for its alleviation, the usual precautions of rest in bed, plenty of fresh air, disinfection of bedding, clothing, utensils, etc., are merely routine measures which experiences have shown to be excellent safe-guards, both for the welfare of the patient, as well as for the protection of those about him, in all forms of infectious diseases, but with medicine there has been such a vast number recommended and used on the "hit and miss" plan, that it may be said with influenza as with most other infectious diseases, the fewer and simpler the medicines and drugs used, the better the ultimate results will be. This does not mean that special drugs such as aspirin, opium, camphor, creosote, and others shall not be used when an occasion demands, but that they shall not be given unless indicated. The main idea to keep in mind in the treatment of influenza is that of elimination, at least trying to help the patient to eliminate the toxins as rapidly as possible through the skin, the bowels and the kidneys, plenty of liquid, especially lemonade, should be given freely, but there appears to be no special reason for restricting the diet, except the quality should be restricted to easily digested food, possibly the cough mixtures containing codeine, ammonium chloride, or the iodines may prove beneficial, and for the acidosis large doses of sodium bicarbonate has proven very valuable in my hands, the value of prophylactic vaccination against influenza and pneumonia has received a great deal of attention from the medical profession, and much effort has been expended in trying to find or perfect the right bacterial mixture which would prove successful in preventing the disease, but as yet no vaccine has been perfected that will really prevent and although thousands have been vaccinated with apparently some good results, the vaccination against influenza is still wholly in an experimental stage.

The proof for or against the efficiency of the various vaccines now on the market cannot be established in a short time, as the tendency of all acute respiratory diseases is to recovery. The vaccine must stand the test over a long period of time in the hands of those who are accustomed to the use of vaccine prevention, and who have not only an interest in collecting data, but also the ability to draw correct conclusions from the results obtained. Therefore, in the opinion of those best competent to judge, it appears that the final solution of the problem of influenza and pneumonia prevention, through vaccine, will have to await the coming of another epidemic.

I believe that anyone who has made a careful survey of the existing literature must be compelled to confess that we do not know what the cause of influenza is, while the influenza bacillus has been charged by a number of our best authorities as being the cause, yet this conviction has been seriously questioned by others just as competent observers, who hold an entirely different opinion, and even Pfeiffer himself, who first gave the etiology of influenza as being due to influenza bacillus, seems to be somewhat in doubt, and says there are a number of weak spots in the theory that influenza bacillus is the primary cause of influenza.

INDUSTRIAL PSYCHONEUROSIS*

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No classification of functional nervous diseases following accidents and injuries has been entirely satisfactory and because of the conflicting opinions regarding the nature of these affections, it is not likely one will be found. Psychoneurosis is a general term that covers all forms of nervousness and the increasing litigation associated with this type of ailment has caused it to assume a very important place in medical jurisprudence.

Attorneys still adhere to the term traumatic neurosis, but I believe most physicians do not hold this phrase in good repute for the reason there is no definite functional nervous condition due to trauma that deserves the dignity of a clinical entity. All forms of nervousness associated with accident or injury are of the same types as those due to other causes and fall into one of the well known groups, as for instance, hysteria, neurasthenia or a combination of two or more members of these groups.

Therefore, I prefer the general designation of psychoneurosis without any attempt, in most instances, to a more specific diagnostic limitation.

The experience of medical officers in war time has furnished valuable information concerning psychoneurosis and the first fact established, is that almost never has severe physical wounds been associated with generalized functional nervous disorder. On the contrary, psychoneurosis is common in patients who have sustained none or only trivial physical trauma, but whose injury was associated with strain and stress or great emotional shock such as fear or grief. It is not only fear of physical danger that helps to precipitate the nervous attack, but distaste for the nature of the occupation or aversion to the environment, or resentment towards employers, or sense of failure may largely enter into the etiology. These psychical disturbances may be entirely unknown to the patient and thus not enter his consciousness.

As stated above, minor injuries sustained under great emotional or physical tension, may lead to severe functional nervous disorder, as for instance, a trivial injury to the arm. Following such an injury, there is a brief period of natural "defense immobilization" even in the absence of a nerve, bone or muscle trauma. To some persons this circumstance may suggest a paralysis and be mentally elaborated to the fixed idea of permanent organic paralysis of the arm. All this without any conscious desire to malinger or exaggerate. Now, if in addition, a physician drops a hint that possibly the brachial plexua may be damaged, the patient is confirmed in his belief as to paralysis and the seeds of permanent invalidism have been sown.

The statement just made furnishes an opportunity to point out here the importance of having these patients seen early by a competent, level headed physician, who should make a thorough, painstaking examination, and without suggestion of any kind to the patient, arrive at a definite conclusion. In this way the patient will not be given a false idea as to the gravity of the trauma and may be prevented from needlessly becoming a parasite on the state.

Since my views have not changed in the last two years, I will quote extensively from a paper I read before the Southern Medical Association and which was printed in the Southern Medical Journal, Vol. XIX, No. 4, pages 266-267.

"The best therapeutic agent in the treatment of traumatic neurosis undoubtedly is return of the patient to regular work. The very nature of the agent producing the injury, with the accompanying circumstances and the mental processes involved, make this true."

Suppose, for example, that an employe received a slight trauma to the head or other part of the body, or his duties produce a muscular "strain', or he receives a "jerk" or "fall". He may or may not cease work immediately, but he afterwards remembers he was unconscious for a short while or at least "dazed".

He fails to return to work, notifies his employer he has been injured and says he has headaches, feels dizy, is easily exhausted and his heart palpitates and he "shakes" if he exerts himself. In addition he notes that he sweats easily and profusely and there may be weakness and numbness of a leg or arm. It is then that the mental process sets in that causes him to think he is seriously injured and deserving of compensation for an indefinite period, which may cause him to settle down

*Read before the Section of General Medicine, Oklahoma State Medical Association, Tulsa, May, 1928.

to a life of invalidism, although he is able to be up and about.

In contrast to this take a similar injury to a farmer or a person engaged in an occupation in which compensation is not a factor. No one ever heard of such prolonged disability in their cases following trifling injuries. Yet these trifling injuries are occurring every day in agricultural and non-compensated pursuits.

Common sense makes it apparent that there could be no lasting or serious injury in these cases because of the trifling nature of the agent producing the trauma. But when the family physician comes in following a trifling injury to a person eligible to compensation and makes a diagnosis of traumatic neurosis and the representative of the insurance carrier visits the patient and then another physician, designated by the Industrial Commission, or the insurance carrier, or the patient, is called in, there is no question in the mind of the patient that his condition is serious. Too many persons are interested in him. His case just has to be serious or so many would not be interested. Here is where the danger of chronic invalidism appears. The thing that the doctor and all interested should do is to get the patient back to work and disabuse his mind of the idea that he is in a serious condition.

Let him become thoroughly and honestly convinced that he is an invalid and he is lost as a producer, and the compensation is lost, and you and I, as members of society, pay the bill. There is no reason, if the patient is handled right, that he should not be an economic asset instead of a liability.

We physicians, too, are largely to blame. We have evolved a nomenclature ranging all the way from traumatic neurosis to split infinitives in endeavoring to establish minute and imaginary differences in types. If the claimant seems agitated, it is anxiety neurosis. If he is just tired, it is neurasthenia. As a matter of fact it is just nervousness and is not a disease at all. It is a condition, though, that is prolonged and sometimes initiated by repeated examinations and conflicts with claim adjusters.

Physicians deserve censure for these hair-splitting diagnosis. These differences often are merely technical and have no real significance, but the hearings for compensation are before laymen and not physicians and consequently these superfine diagnoses of types confuse the layman and give added importance to the case.

The physician should help the claim adjuster settle the case fairly, both to the claimant and the insurance carrier, but he certainly should get it adjusted as soon as possible and get the patient back to his regular occupation.

Claim adjusters have lost faith in human nature because of exorbitant demands of many accident victims and it is frequently the unenviable task of the physician to serve as a balance between these men and the claimants.

The physician should always bear in mind a circumstance which I believe to be a fact; these same claimants are not conscious malingerers, but firmly believe in their symptoms as narrated. Why shouldn't they? Haven't many persons shown great interest in their cases since their injury?

Claim adjusters should be men of the greatest possible tact and kindliness, whose aim should be conciliatory and not antagonistic, and for the good of both claimant and insurance carrier, they should endeavor to settle each claim in the shortest possible time after the injury and thus get the man back to work.

Failure to get the claim settled early, the display of so much interest, and use of the many and varied terms as diagnosis in these cases have made permanent invalids of numerous accident victims who really have nothing the matter with them.

I know one woman employe who was struck by a falling locker in the dressing room of an industrial plant, receiving nothing more than a "jar'. She was not even pushed aside, but she has not worked for weeks. She is performing her household duties and drawing compensation nearly equal to her former wages.

This is a typical example of so-called traumatic neurosis. It is obviously unjust to the insurance company and certainly not good for the woman's morale.

Again, let me urge that the patient be gotten back into regular occupation at the earliest moment. Remember there are no long drawn-out cases of invalidism among farmers and others engaged in non-compensating occupations from this cause.

THE CRIMINAL RESPONSIBILITY OF THE MENTALLY ILL

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The psychiatrist does not excuse crime, he only tries to explain it. I make this statement by way of introduction because of the general belief that the psychiatrist is making a desperate effort to excuse crime. This idea as will be seen in this paper is entirely wrong.

During the past ten years two very important psychiatric surveys of prisoners have been made in the United States. The first survey to be considered is that of Dr. Bernard Glueck, psychiatrist, to Sing Sing prison, New York, in which 608 adult prisoners were carefully studied in an uninterrupted series of admissions to the prison. 66.8 per cent of those examined had shown throughout life a disposition to be asocial and to have difficulties in adjusting to ordinary life. A fairly large per cent of these prisoners had some type of classifiable mental disease, and in most cases the crime directly or indirectly attributable to the mental state. The other survey is that conducted under the direction of the National Committee for Mental Hygiene, whereby 1,288 prisoners in the jails of New York were subjected to careful psychiatric examinations. Of this number 77 per cent were found to have all the way from mild mental disorder to the severest mental deteriorations. The best of them had always had difficulties in adjusting to their environment while the worst types were frankly insane.

In this paper I will name a few of the commonest types of mental illness and the type of crimes which they may commit.

The first disease to be considered is kleptomania. Kleptomania is a compulsion neurosis in which the compulsion forces the victim of the neurosis into a certain type of stealing. This stealing is usually differentiated from the stealing of the ordinary thief by the fact that the kleptomaniac rarely steals that which has intrinsic value. But instead he usually steals that which has little or no value and his thefts are nearly always of the same articles. Most frequently it is a woman's undergarment, a gown, a handkerchief, a button or a lock of hair. These objects of theft of the kleptomaniac have a powerful emotional (sex) value. After stealing the object he holds it to his breast or pelvis and receives his emotional stimulus and never again has that object any more value either emotionally or intrinsically considered. He hoards or hides the articles after receiving his emotional stimulus but never sells them. Not so with a common thief for he steals that which has an intrinsic value and converts it into money for his own use. The kleptomaniac is perfectly powerless in his compulsion to steal, no amount of persuasion or no amount of punishment will do the kleptomaniac any good because his stealing is the expression of a very serious and deep neurosis.

The second disease to be considered is the manic-depressive insanity. This disease is characterized usually by two phases, a high phase and a low phase. During the high phase or manic phase the individual thinks fast, he acts fast and is emotionally elated. His rapid thinking may assume that state commonly spoken of as "flights of ideas" in which flight the ideas come tumbling through the mind in a rapid and unsystematized fashion. While in this high phase, because of his excitement, flights of ideas and emotional elation he may commit crimes. While his crimes are usually of the minor types such as stealing, forging, and sex crime, yet, we find that he does quite frequently commit murder. In a study of 646 cases admitted to the Matteawan Criminal State Hospital of New York, showed that 2.9 per cent of the homicides living there were committed by the manic-depressives in a high phase. It is needless to say that while in a low phase the danger is not that of homicide, but rather that of suicide. In fact every manic-depressive either in a mixed phase or a low phase must be considered as a potential suicide.

The third type of disease to be considered is that of paresis or as classically known as general paralysis of the insane. This disease as commonly known is a syphilitic degeneration of the parenchymatous tissue of the brain. In this degeneration of the brain we find early and definite mental symptoms. In the early stages the conduct is usually impulsive and there is early shown a marked character change. In this character change there is marked loss of judgment and the power to conduct oneself in harmony with social customs. He frequently commits crimes of sexual nature. He frequently commits offenses against

*Read before the Section of General Medicine, Oklahoma State Medical Association, Tulsa, May, 1928.

the life and person of little girls. He also may commit the most heinous crimes and a fair percentage of the homicides are committed by him. In the study of cases mentioned above at the Matteawan Hospital, the same percentage of homicide was committed by the paretic as that of the manic-depressive. Here we wish to say that whenever a man in the fourth or fifth decade of life commits a crime more or less serious, one should consider that we are in the presence of severe illness. And, any man in middle life who commits a sexual crime against children his spinal fluid should be taken at once as the diagnosis is likely to be made paresis.

The fourth group of the mentally ill to be considered is that of the psychopathic personality. This is a very large group and contributes heavily to criminal acts. The illness ranges all the way from a mild instability to severe illness. Running through the most of the cases belonging to this group can be seen trends which lead over into the groups of true insanities. The statistical manual published by the National Committee for Mental Hygiene says: "In fact all of the so-called constitutional psychoses, manic-depressive, dementia praecox, paranoia, psychoneuroses, etc., may be considered as arising on a basis of psychopathic inferiority." Also there are types of which one feels like saying that they are neither sick nor well, neither sane or insane. Yet this group furnishes a large percentage of the criminals, tramps, and moral perverts. They furnish 14.7 per cent of the homicides residing at the Matteawan Hospital at New York.

The fifth group to be considered in this discussion is the moron or high grade imbecile. This group is very large, there being probably a half million of them running at large in the United States. The moron as a class is always dangerous because of a low intellectual level of 12 years or less, being always coupled with a low emotional level, usually lower than the intellectual level, and because of this mental deficiency he commits a vast amount of crime. They are always the tools of more intellectual and vicious criminals. They often steal, kill and commit heinous crimes at the suggestion of other criminals. They appear to be helpless in the hands of their baser cravings, and in the above mentioned study of homicides they furnish 17.6 per cent.

The sixth group to be considered is that of the epileptic . The epileptic is especially dangerous either preceding or following an epileptic convulsion. He may also be very dangerous while in an "epileptic furor". His criminal acts may be committed during the dream states after the convulsion in which the patient to all appearances is perfectly normal. In such states he may appear to commit intelligently the most heinous crimes and yet following the acts has no memory of what has happened. The epileptic should always be looked upon as a very dangerous individual to run at large. He is nearly always potentially a criminal.

The last group to be considered is that of the dementia praecox or as is commonly called at the present time "schizophrenia". The word schizophrenia meaning a splitting of the mind. S. Sheldon Glueck, professor of Penology in Harvard University, says: "That dementia praecox exacts perhaps the heaviest toll from society of any of the psychoses. Its costs to the state, whether criminal or otherwise, is appalling." This disease leads to almost any conceivable crime. In the state of New York alone dementia praecox causes a loss, either directly or indirectly, of ten million dollars annually. One can do no better than to quote from Judge Olson of Chicago, in regard to the work done in his municipal laboratory, as quoted by Dr. Glueck as follows: "The judges send only suspected cases to the laboratory. Out of 779 cases in the boys' court, there were 654 suffering from dementia praecox, or about 84 per cent. In the moral court, out of 464 cases of females, 260 or 36 per cent, were dementia praecox. Out of 359 cases of males in the moral court, 107 were dementia praecox. Out of 657 cases of males in the domestic relations court, 236 were dementia praecox. In the outside criminal branches of 270 males, 107 were dementia praecox. Out of 152 females, 84 were dementia praecox. You will observe, therefore, that dementia praecox plays the highest role and is the criminal psychosis par excellence."

In dementia praecox there is always more or less "splitting of the psychic functions and the thought processes are controlled by groups of ideas (complexes), that have a strong emotional interest for the personality." (Bleuler) The emotional content appears to be split away from intelligence and thereby leaving the individual helpless as far as his conduct is concerned. In the above named study at Matteawan State Hospital 32.4 per cent of the homicides were committed by this group.

So much for the consideration of the various types of the insane which frequently are offenders. At this time I wish to make a plea for the early recognition, the early study and the early incarceration of the mentally ill. Every mild offender should be carefully studied before he is turned back upon society, and any young adult upon whom the diagnosis of dementia praecox can be placed should never be turned back upon society unless a Board of Psychiatrists has carefully examined him and pronounced him safe to be returned to society. What is said of dementia praecox may be said of other definite types of insanity.

Dr. S. Sheldon Glueck, Dr. Bernard Glueck and Dr. William A. White all feel that at least fifty per cent of the prisoners residing in penal institutions are there because of mental illness, and that being the case it behooves us to inquire into the mental status of every offender. I have no solution for criminality but when the time comes that a Board of Psychiatry will examine into the mental status of every individual found guilty of a felony, and if the criminal is afflicted with a serious mental disease, shall be shut up in a hospital and confined until he is well, we shall have taken a long step forward.

The states of New York and Michigan are operating under the Baumes Law, which law is especially designed for the protection of society. This law, among other things, commits a man to life imprisonment upon the fourth conviction of a felony. I herewith include a copy of the important section of that law as operating in Michigan at the present time:

"A person, who, after having been convicted within this state of a felony, or an attempt to commit a felony, or under the laws of any other state, government, or country, or a crime which if committed within this state would be a felony, commits any felony within this state is punishable upon conviction, as follows: If the subsequent felony is such that, upon a first conviction the offender would be punishable by imprisonment for any term less than his natural life, then such person must be sentenced to imprisonment for a term not less than one-half of the longest term nor more than one and one-half times the longest term prescribed for the first conviction of such offense.

"A person who, after having been twice convicted within this state of a felony or an attempt to commit a felony, or under the laws of any other states, governments or countries, of a crime which if committed within this state would be a felony, commits any felony within this state, is punishable upon conviction as follows: If the felony for which such offender is tried is such that upon the first conviction the offender would be punishable by imprisonment for any term less than his natural life, then such person must be sentenced to imprisonment for a term not less than the longest term nor more than twice the longest term prescribed by law for a first conviction of such offense.

"A person who, after having been three times convicted within this state, of felonies or attempts to commit felonies, or under the law of any other state, government or country of crimes which if committed within this state would be felonious, commits a felony within this state, must be sentenced upon conviction of such fourth or subsequent offense, to imprisonment in a state prison for the term of his natural life. Offenders sentenced under this and the last two preceding sections shall not be eligible to parole before the expiration of the minimum term fixed by the sentencing judge at the time of sentence without the written approval of the judge of such court or any judge of such court if the sentencing judge is not then serving. A person to be punishable under this and the last two preceding sections need not have been indicted and convicted as a previous offender in order to receive the increased punishment therein provided, but may be proceeded against as provided in the following section."

It is the conviction of the writer of this law that any criminal convicted four or more times is a confirmed criminal and should never be turned back upon society.

On the fifth day of this month of May, 1928, there were in the city jail of Oklahoma City, 68 prisoners. Of this number 13 were in this jail for the first time, and 50 of the 68 have been in this jail from four to 20 times during the past five years. Were the Baumes Law operating in this state these 50 repeaters would be sent to the state prison for life, and the crime of Oklahoma City would be thereby reduced. For the past 50 years England has been committing her third offenders to life imprisonment and thereby reducing crime to a minimum in the kingdom.

Once more I make a plea for the early recognition of the mentally ill and the confirmed criminal and to shut them up before they commit a major crime. Hickman gave warning for several years that he would commit major crime. Also Harrison Nole was in Belvue Hospital, New York City, for a short stay two years prior to the commission of his horrible crime. Both Hickman and Harrison Nole were diagnosed as dementia praecox, paranoid types. And, today's paper, May 5, 1928, contains the account of a praecox who, at Eldorado, Kansas, shot and killed his father and mother, five sisters and brothers; piled them up in a kitchen, covered them with kerosene and set fire and burned the house in an effort to destroy the bodies. This boy, for the past two or three years, was recognized by the neighbors as a dangerous eccentric.

In conclusion I wish to repeat one of my first sentences in this paper and say that the *Psychiatrist does not attempt to excuse crime, but to explain crime,* and furthermore that the psychiatrists of America are doing everything in their power to recognize the potential criminal and shut him up and thereby protect society.

THE INTERSTITIAL TRANSPLANT OF THE ROUND LIGAMENTS FOR RESTORATION OF THE RETROVERTED UTERUS*

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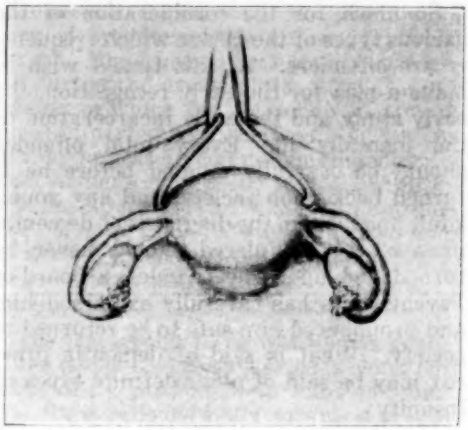
CLINTON

With the multiplicity of methods of correcting retro-displacement and the diversity of opinion about the causation of this condition, is it any wonder that the mention of this subject is a signal for a "free for all?" When we find ourselves confronted by medical literature describing well past one hundred surgical procedures for correcting this one condition it is quite significant that we have not as a whole fully co-ordinated the causative factors with methods of procedure.

Much of the many sided discussions and presentations of this subject are attempts to justify an individual conception of correcting this condition without first considering properly the many factors contributing to our pathology.

*Read before the Section on Surgery and Gynecology, Annual Meeting, Oklahoma State Medical Association, Tulsa, May, 1928.



—Drawing After Yeatman Wardlow.

While it is not our purpose in this presentation to discuss the many causative factors of retrodisplacement, we, however, deem it proper to briefly discuss a few of the more generally accepted principles which should be considered when making a survey of the pelvis in anticipation of surgical interference for retrodisplacement. Nature evidently designed the horizontal position in the pelvis for the uterus with a rather wide excursion of movements in both the pregnant and non-pregnant uterus. All of such movements should occur with the uterus assuming in a degree this horizontal position.

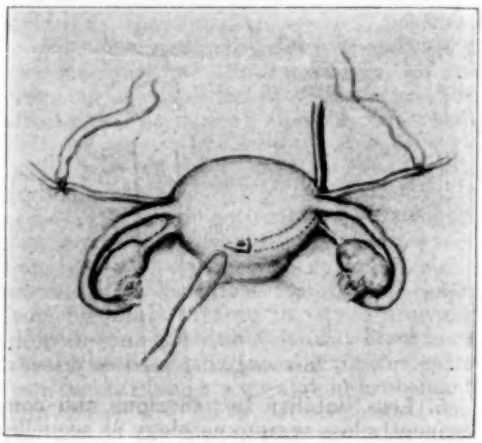
Retroversion having occurred does not have a tendency to correct itself and retrodisplacement regardless of symptomatology is most undesirable. The infantile and undeveloped uterus, though retroverted, does not always give smyptoms, probably due in some decree to lack of nerve development and less weight of uterus itself. The retroversion of the infantile uterus does not often require surgical intervention and when surgery is employed often proves disappointing.

In surveying the pelvis with a view to restoring retro-displacement we should know the anchoring ligaments of the uterus are intact and if not they should be repaired before attempting restoration. In shortening the round ligaments by any method in which we may confidently expect a lasting support after correction we must not over-correct. Nature has allowed for the necessary displacement of the uterus and when too tightly fixed forward we may get unpleasant bladder symptoms, therefore we should allow for a compensa-

tory displacement with distention of the bladder.

With the exception of hysteropexy most of the numerous operations are with the view that the excess in length of the overstretched ligament should be eliminated by excision or by looping. This view is obviously opposed to the fundamental surgical principle that the ideal treatment is that which restores it to the normal. The ideal treatment should be the restoration of the overstretched ligament to its original dimensions.

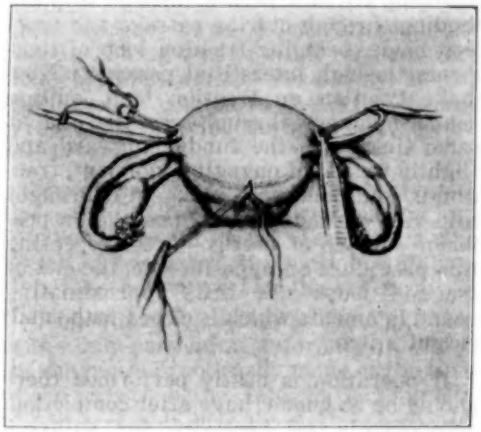
Assuming that associated pelvic conditions are favorable for correcting retrodisplacement of the uterus, it is a great relief to the surgeon if he can feel confident that he has a knowledge of and experience with a method that will give a lasting and uniformly good result.



—Drawing After Yeatman Wardlow.

In 1921 we reported before this section the result of 32 cases of correction of retroversion by the interstitial transplant after the method of the late Dr. Yeatman Wardlow as first published by him in December, 1919, Surgery, Gynecology and Obstetrics. During the seven years intervening since our first report we have employed this method with very few exceptions with increasing favor and confidence and through a series of cases large enough to better base an opinion.

In facilitating the technique of this operation Dr. Wardlow devised an instrument which he designates as a "hysterotome," which consists of a blade of curvatures, length and other dimensions suited to make passage in curved directions through the uterine wall. It is fitted with cutting edges at point only. While the shaft consists of a rounded dilating or non-cutting portion. Dr. Wardlow has three blades made in three sizes for various classes of cases and fitted with an interchangeable handle which permits of shifting of the direction of the blade at the convenience of the operator and to meet any necessity for variation in a given case.



—Drawing After Yeatman Wardlow.

STEPS OF THE OPERATION

After opening the abdomen and elevating uterus the round ligaments are caught by mouse tooth forceps at such point as will allow approximation directly backward on posterior surface of uterus and at this point on ligaments, apply catgut ligature by having a twelve-inch ligature with both ends threaded into eye of catgut needle and passing needle under round ligament, where forceps are applied, remove needle from suture and pass two ends through loop and tighten loop on ligament, applying hemostat forceps to distal ends of suture, repeat procedure on opposite ligament. Supporting uterus in one hand the hysterotome is inserted into the tissues at point of origin of round ligament on anterior surface of horn of uterus and rather to anterior margin of same. The instrument is now passed backward through uterine horn, just under interstitial portion of tube, keeping instrument beneath surface vessels at this point, and continuing its direction slightly downward, and inward through the uterine wall to a point in median line about one inch below the tip of the fundus uteri.

Here the point of the instrument is caused to emerge through small incision previously made through outer layer of

uterine wall. The eye of instrument is now threaded, carrying loop back through passage as hysterotome is withdrawn. If before withdrawing the hysterotome, a mouse tooth forceps is applied to posterior portion of puncture wound, including tissue of round ligament, it will steady the uterus and facilitate work for the following steps. The ends of traction loop of ligament are now passed through loop extending through uterine passage and traction made, bringing traction loop of ligaments through interstitial passage. Now make traction on traction loop, pulling round ligament through passage and at same time push the fundus forward and slightly to side of engaging ligament, traction is continued until ligament is brought into view at distal end of passage on posterior surface of uterus. After repeating this procedure on opposite side, the end of traction loops are tied, approximating round ligaments which is closed with small catgut stitch.

If operation is neatly performed there should be no hemorrhage after completion, consequently no necessity for suturing puncture wound, but if, upon completion, there is hemorrhage, small catgut suture should be applied as control. If for any reason the tube is removed the point of puncture may be at this point, with the further technique as described above. As pointed out by Dr. Wardlow we utilize the muscular portion of ligament in loop carried through uterine passage and leave the strong tendinous portion as a sustaining medium.

Care should be used not to get the ligaments too tight, causing a constant pull and strain and subsequent pain, there being no necessity for over-correction in the use of this method to restore backward displacement. Good results following this operation depend to a greater degree upon neatness, kindly handling of tissues and small amount of trauma, than in most other pelvic operations. Dr. Wardlow reported a rather large series of pregnancies following this operation. All his cases (except two cases of confessed criminal abortions) went through pregnancy without complications and stood the ordeal of childbirth with no complications and no relapse to retro-displacement. The pregnancies which have occurred in patients whom we have operated have gone through pregnancy and childbirth with the same ease as those who had not had such operations.

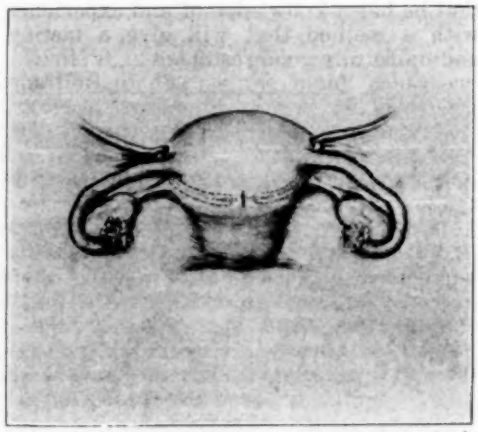
ADVANTAGES

1. It is a proper anatomical adjustment giving better physiological results.

2. It utilizes the strong tendinous portion of the ligament as a sustaining medium and the weakened muscular portion is buried and lessens the danger of adhesions.

3. The portion of interstitial transplant being more muscular will take on the hypertrophic changes necessary for expansion in the pregnant uterus should this condition obtain.

4. Does not disturb the curve through nature's elastic ring at distal end of ligament.



—Drawing After Yeatman Wardlow.

5. Less liability to adhesions and consequently less symptomatology as sequella.

We do not believe this operation offers a disadvantage by being too technical as it is rather easy of application. As our experience has increased in the application of this operation we have grown more confident that it gives better results than any other method so far advanced.

CONGENITAL DEFORMITIES

W. K. WEST, M.D.
OKLAHOMA CITY

In our study of the statistics covering our examinations in the clinics, we find that congenital deformitiess are quite a common cause for children being crippled.

This type of deformity is best treated at an early age. The exact age depends upon the condition. But no matter what

the condition is, the child should be examined at the earliest age possible. Those common deformities which are greatly aided by proper treatment, will be discussed in this paper.

Congenital Club Feet. Congenital club feet cause great disability and disfigurement, if left untreated. But the treatment must be instituted immediately after birth in order to get the maximum improvement. There have been many cases examined in which they have been told by their own physician that it is better to wait until the child begins to walk before treatment be instituted. This advice is injurious to the child, because the normal development of the bone and the soft parts will be only attained by early corrections and retention of the foot in a normal position. For example, where only one foot is involved, it is very important to correct the deformity within the first few weeks if possible, in order that the foot will grow as rapidly as the normal one. In those cases, several years old, we find that after correction the affected foot is smaller than the other foot. This is especially disfiguring in a girl. Looking at it from another standpoint, limited motion of the joints in the ankle and foot is more noticeable in the older, untreated cases, even though the correction has been made and normal weight bearing line obtained. Statistics taken from hospitals that do this type of work indicate that the club feet that have been treated by manipulation and plaster casts from the start show a greater improvement than those who have been operated on. The reason for that is that the manipulation and mechanical retention is sufficient for the child a few weeks or a few months old. In children less than two months old, a slight correction is made without pain, only using the force of the hand while a light plaster boot is applied. These boots should always extend above the knee with the knee at a right angle. Otherwise, they will be kicked off by the child . The force used in correcting the deformity is to gently improve both the equinus and varus tendencies. These plaster boots are changed every two weeks at first, and the time of change is increased when the child grows older.

Older children, beginning at the end of the second year, necessitates some opertive measure. It is impossible to treat a child six or seven years old without division of the contracting tendons and fasciae. And in that type of case in the teens it is advisable to remove some bone, either by a typical arthrodesis or by a cuneiform osteotomy. All cases of club feet should wear plaster casts many months and walk on them, as they maintain proper position of the feet night and day and the walking will help develop the structure in the feet. After the casts are removed, braces are fitted which hold the feet in the proper position as long as necessary. There is a great tendency to recurrence of the old deformity. This type of work requires very little hospitalization. Practically all the cases can be treated in the office, except a few days following the operation, in case one is necessary.

The earlier the child is properly treated, the more satisfactory the end-results, and in the neglected cases, the longer the length of treatment, the more hospitalization, and the less perfect the *end*-result.

Congenital Dislocation of the Hip. This is the only congenital deformity in which the diagnosis is not easily made at the time of the growth of the child. In the majority of cases, if only one hip is dislocated, the mother will notice the difference in the length of the legs. But when both hips are out of place, the child may be old enough to walk but is not able to walk. The child will then be brought to the family physician to find out the cause for this failure to walk at the normal age. At this time, it should be remembered that the hips are up and back of the hip joint socket, and when the child stands erect it causes the spine to be hyper-extended, and a typical lumbar lordosis with a prominent abdomen and very prominent buttocks. If the child has learned to walk in spite of the dislocated hip, which they always do, they have a very typical gait and that is known as the "waddling gait".

In any suspected case of dislocation of the hip, an x-ray should be advised and the diagnosis is very easily made.

It is impractical to try to reduce these dislocations until the child is between three and five years of age, because it is necessary to apply a plaster hip spica for maintenance of reduction for many months. For that reason it is best to wait until this cast can be kept in good condition. From the age of five on, the prognosis is less favorable. However, a reduction should be attempted in the older children. Open operations are necessary some times, but unnecessary when the child can be treated at the most favorable age.

The treatment consists of manipulation and closed reduction under general anesthetic, after the head of the femur has been replaced the leg is fixed in a plaster spica in a position of mid-flexion and complete abduction with knee at right angles. This position is commonly called the "frog leg" position. It is necessary to maintain this position for several months during which time the leg is gradually pulled down to the normal position. Children stand this treatment very well, and with proper nursing come through without any danger whatever.

Congenital Torticollis. This deformity is easily recognized at birth. It is a contraction of the muscles on one side of the neck, but usually the sterno-mastoid muscle is the chief offender. In the untreated cases, this contraction results in a lateral curvature of the cervical vertebrae. It also causes a flattening on one side of the head, as the child grows older. As soon as the child starts to school, it reads with difficulty because of the difference in level of the eyes and in order to get those eyes in position for reading, the spine is curved lower down in a typical compensatory manner. Therefore, it is very important to correct this deformity as early as it is possible, because in the older patients after the muscles have been cared for the bones have developed in an abnormal manner and a further treatment of the curvature of the spine is necessary. This deformity causes a terrific disfigurement.

The treatment consists of manual manipulation of the neck muscles from the time the child is born, but it isn't feasible to do the slight operation necessary for relief of muscle contraction until the child is three years old. This operation is done under a general anesthetic, a small incision being made over the medial aspect of the clavicle. The attachments of the sterno mastoid muscle are divided. It is necessary to use great care in this area, because of the proximity of the jugular vein. The child is then put to bed for forty-eight hours, with only a bandage protection. At the end of that time, any sickness which has resulted from the anesthetic has subsided. The child is then placed in a suspension apparatus and a plaster cast is applied over the head, neck and upper body with the head in over correction. This cast is changed every few weeks but some type of mechanical apparatus worn for several months. This treatment is not dangerous and the results are very gratifying.

Obstetrical Paralysis. This is not a true congenital deformity, being an injury to the arm and shoulder at the time the child is born. Part of the nerves making up the brachial plexus are pulled apart by tension and as a result of this nerve division the child has a partial paralysis of the arm. If the child is left untreated, a typical contracted arm will result, and there is only partial return to the power in the arm. However, the nerves do grow back together in most cases, and there is some power in all muscle groups but it takes several months for this type of nerve injury to heal. But during this time, the contraction resulting from the loss of proper muscle balance becomes so fixed that it is necessary to do an open operation to free them, and then the result is only helpful. On the other hand, if the child is treated immediately after birth by some type of abduction apparatus, in which the arm is held in abduction and extreme external rotation, the child will make a splendid recovery after the normal nerve impulses reappear.

SUMMARY

This is a report of average results obtained in the care of crippled children of the type disabled because of congenital deformity. There is no other kind of case which is more greatly benefitted with so little danger.

INTRAVENOUS MEDICATION*

C. R. HUCKABAY, M.D.
VALLIANT

The transfusion of alien blood for therapeutic purposes and the intravenous injection of medicines had their scientific origin in the 17th century, but for ages before that time the idea had been present in the minds of those who carried on the medical tradition.

Ancient History. Allusions in the fragments of Egyptian history which have come down to us indicate that even this ancient people had some knowledge of in-intravenous therapy. There also existed a copy of an ancient Hebrew manuscript which read:

"Naam, leader of the armies of Ben-Adad, King of Syria, afflicted with leprosy, consulted physicians who, in order to

*Read before the Semi-Annual Session of the Southern Oklahoma Medical Association at McAlester, June 20 ,1928.

cure him, drew out the blood from his veins and put in that of another."

There are various references along similar lines, until, in the writings of Labavius, published in 1615, we find a passage translated by Brown as follows:

"Let there be a young man, robust, full of spirituous blood, and also an old man, thin, emaciated, his strength exhausted, hardly able to retain his own soul. Let the performer of the operation have two silver tubes fitting into each other. Let him open the artery of the young man and fit into it one of the tubes, fastening it in. Let him immediately after open the artery of the old man, and put the female tube into it, and then, the two tubes being joined together, the hot and spirituous blood of the young man will pour into the old one's as if it were from a fountain of life, and all of his weakness will be dispelled.

"Now, in order that the young man may not suffer from weakness, to him are to be given good care and food, but to the Doctor, hellebore."

Brown adds that he "cannot imagine why the Medicus should need hellebore, but perhaps it was on the principle that a veratrum cock-tail might reduce his blood pressure after his exciting experiment."

No rational application of transfusion or intravenous medication could have been possible, however, before the year 1613. Then is when Wm. Harvey announced his discovery of the circulation of the blood. The possibility of giving medicine by mixing with the blood streams probably coexisted from the beginning with the idea of transfusion.

The first definite record of any such attempt is related by Robt. Boyle, a celebrated physicist and chemist of the 17th century who stated that the suggestion of intravenous medicine was made to him, not by a physician, but by an architect, no other that Sir Christopher Wrenn, the builder of London's St. Paul's Cathedral.

Both French and German historians also advance claims as being the first to practice transfusion. Their claims are based on reputed operations performed about the same time as those of Wren.

Early History. In the early history of intravenous medicine, we find such drugs as scammony and resin of jalap were injected in the attempt to cure syphilis.

Hale, of Boston, in 1814, injected himself with oleum ricini and survived the experiment. Bacelli, in 1890, used quinine intravenously in the treatment of malaria and Landerer, in 1892, injected sodium cinnamate and balsam of Peru for tuberculosis. Gauntier injected sodium caccodylate for pernicious anemia in 1897, while Crede employed silver salts to overcome infections in 1901.

It would seem that the introduction of the hypodermic needle in 1845 would have hastened the general adoption of intravenous therapy, but such was not the case. It marked an epoch since it resulted in the administration of drugs by means other than the mouth, yet for years the hypodermic syringe was an emergency treatment.

Physicians to whom direct medication suggested itself failed to introduce the needle of the syringe into the vein and thus make it possible to inject drugs directly into the blood streams.

Then came the discovery and announcement of salvarsan or Arsphenamine by Ehrlich. His work brough about the deep injections of drugs into the tissues which in turn developed into introduction of the remedy into the vein. As soon as medical men began to appreciate the fact that arsenical compounds could be intravenously injected, the idea suggested itself that the same method could be employed to place other drugs directly into the circulation. But, the intravenous route did not quickly become practicable. Unpleasant reactions which followed the administration of the arsenicals were ascribed to the fact that the remedy was placed directly into the blood stream and not to faulty technic. Critics jumped to the conclusion that the method itself was dangerous and unsuitable except in the hands of any but an expert. The ancient bugaboo of the danger of injecting air into the vein was emphasized. But by these very facts scientific curosity was aroused.

Investigations were carried on to learn the nature and causes of such reactions and vitally significant facts were brought to light. It was found and demonstrated that the majority of unpleasant and dangerous reactions could be ascribed, not to the placing of the remedy directly into the blood stream, but to the practices accompanying the method employed. The volume of the solutions injected at the time were entirely too large.

It was also found that some reactions were the results of using water which was distilled and therefore thought to be sterile but which, on investigation, proved to be water contaminated with albuminoid ammonia or other products of fungus growth. These were demonstrated to often exist in the very still used for the preparation of the water. Unfortunately, the importance of a properly prepared water is not yet fully appreciated by some doctors.

It also came to be realized that the preparation of solutions for intravenous use calls for special knowledge and special pains. The exceptional care required in their production at once removes intravenous solutions from the class of products that can be prepared on the spur of the moment.

Present Status. The practical results of study, experimentation and research which followed these difficulties lead to their correction. Under present conditions, intravenous therapy when properly indicated is practical, safe and has superiorities over any other method of drug administration. This statement may be proved by results. The general circumstances whose presence in my opinion call for the intravenous mode of administration are these.

1. When need for rapidity of therapeutic action is required.

2. When the greater necessity and positiveness of direct medicine is desired.

3. When chemical changes of the drugs by the digestive apparatus is to be avoided.

4. When gastric disturbance is encountered by the same drugs given per mouth.

In fact the field is so wide seemingly there is no limit or bounds to its usefulness. As we all know, where we administer medicines by mouth or rectum there is a lack of confidence as to just what this medicament is going to accomplish.

Quite different to intravenous medication, there is a feeling of security of confidence of what your results will be, when you have started your treatment.

Specifics. The question of specific medication has resulted in the development of many very valuable medicines and serums and not wholly to the medicines, but to their purity and mode of administration.

As to anti-diphtheritic serum, we will have to admit that it comes as near being a specific as anything we have, and too, we will have to admit that it is much more effective put in the vein than intramuscularly or subcutaneously.

Salvarsan. Another great advent, was the bringing forth of salvarsan and its twin sister neosalvarsan. They are lauded as near a specific as anything our profession commands to date, yet they are less than a quarter century in existence. All this being true they would be of no avail if it was not for intravenous administration and as we all know there has been great improvement in their administration. Today the cross roads doctor can give the neosalvarsan in 10 to 20 cc. instead of the original pint, pust as effectually as the most skilled.

Quinine. This great old medicine has stood the test, took its place in the ranks and file almost since man was. Has been given for more ailments, for lack of something else to give than all others combined. And at that it has not betrayed our confidence. It will come nearer curing everything than any one medicine. At the present time in my hands it comes nearer being a specific in pneumania than anything I have resorted to. Doubtless you have all received literature from Merck Co. regarding pneumoquine. The base is quinine and they claim to cure pneumonia in three or four days with this preparation.

Heart. The great majority of you men will throw up your hands when it comes to giving quinine intravenously, as you are afraid of weak hearts. Singer and Winterberg state that quinine was formerly much used in the treatment of cardiac affections, but in modern times has been over looked. Winterberg states that quinine dihydrochloride 5 to 10 grains in 10 to 20 cc. of distiiled water will control a functional tacchycardia quicker than any other medicament. Wenchenbeck unqualifyingly supports the proof provided by Winterberg as to the efficiency of quinine intravenously in various heart lesions, obtained in extensive clinical tests.

My Experience. During the last three years I have treated various diseases almost exclusively by intravenous route, with very satisfactory results. Have given over 3,000 shots in last thirty months. Given over 1,200 intravenous shots of quinine dihydrochloride and quinine dihydrobromide.

Diseases Treated. Pneumonia over 100 cases in three seasons, over 50 winter of

1928. I mean lobar pneumonia. 1 per cent mortum, average time of crisis is 72 hours, if uncomplicated. Malaria almost innumerable, as you understand that I live within six miles of Red River and the same distance from Little River. Six cases of malarial hematuria last fall. Pellegra, near 30 cases. Rheumatism over 30 cases. Arteriosclerosis over 30 cases. Cardio-vascular-renal five cases. Gonorrhea 30 to 40 cases. Mastitis four cases. Puerperal eclampsia two cases. Tetanus one case.

Pneumonia. First case, John Love, 21 years old, December 24, 1926, a cook. Was found unconscious. Three doctors, including myself, first diagnosed appendicitis. There was so much adominal rigidity. After two narcotic hypos he expectorated characteristic brick dust sputum. Examination of thorax revealed lobar pneumonia in both lower lobes. At 5 P. M., December 24, 1926, temp. 100, pulse 160, almost imperceptible. Gave 15 gr. quinine dihydrochloride at 5 P. M. At 9 P. M. temp. 104, pulse 140. At 9 A. M, December 25, 1926, temp. 101, pulse 120. Gave 15 gr. quinine dihydrochloride. At 9 P.M. temp. 100, pulse 110. At 9 A. M., December 26, 1926, temp. 97, pulse 70, profuse sweating. Left lung resolved sixth day of disease. Right resolved seventh day, and was in town the ninth day.

Pneumonia. Fourteenth case. Mrs. Mason, 79 years old. Had flu supposedly for five days. At 11 P. M. fifth day I saw her. Temp. 104, delirious, consolidation both lower lobes. Gave her 15 gr. quinine dihydrochloride intravenously. Eleven hours later I gave her 15 gr. quinine intravenously, and at this time temp. 102, pulse very weak. Next day temp. 96, pulse 68. Lungs still solid. Gave 32 gr. sodi iodide and 3-4 gr. guiacal and 3-4 gr. creosote each day for three days and dismissed her. She is still living.

Pneumonia. Nineteenth case. R. W. Wilson, 33 years old, ferryman and fisherman on Red River. Saw him fourth day of disease; fever 105, very sick, vomiting abundance of very green bile., pain was so great in right side had to give 1-4 gr. morphine. Right middle and lower lobe very solid and he was very icteric. Gave him 15 grs. quinine dihydrochloride intravenously, never saw him again until the seventh day; temp. 104, very delirious, very yellow, still vomiting very green, more like skimmings of molasses. Under the bed was a gallon molasses bucket half full of very bloody urine. Malarial heraturia complicating. The outlook was anything but promising. Figured that I could not hurt a dead man. Gave 15 gr. quinine dihydrochloride intravenously; in twenty-five minutes gave 32 gr. sodi iodide, 3-4 creosote and 3-4 guiacal in other arm. Saw him in 24 hours; temp. 96, pulse 70; smoking a cigarette when I went in his tent.

Asthma. Boy 14 years old. Had it since five years old. Was under Dr. C.'s care. Gave adrenlin chloride from once to three times monthly, 5 to 10 m. and Dovers powder until it lost its effect. Was brought to me almost suffocated. Asked me to give adrenlin as other doctor was out of town. Gave him 32 gr. sodi iodide, 5-8 creosote and 5-8 gr. guiacal—gave immediate relief. Gave same every other and every third day until given six doses. After fifth dose his bronchiolis resolved and he expectorated an abundance of fibrinous matter that looked more like spaghetti than anything else. This was April, 1926. Had slight attack in July, 1927; I gave one dose as above, otherwise had no further occurance; he has almost doubled in weight.

Flu. Near 100 cases this season. One to two doses of 10 grs. quinine dihydrochloride in 20 cc. doses clears it in 6 to 36 hours. Average 12 hours. The higher the fever the better quinine acts and has less reaction.

Pellegra. I use Martin's treatment, of Hot Springs.

Aortic Regurgitation. E. J. R. Systolic 90 diastolic nil, 66 years old, atrophic, Brought up to 110 and 60. John Abbott, 18 years old, systol 85 diastolic nil, hypertrophy and dilated. Brought up to 110 and 70. Three other cases systolic 90, diastolic 30. Treatment of all were the same. As they all had chronic malaria. Gave 7 1-2 grs. quininedihydrochloride and 15 grs. sodi caccodylate every other day until gave three doses. Then every third day 15 grs. sodi caccodylate until three doses. Those with hypertrophy gave 31 grs. sodi salicylate every other day, for three doses. The salcylate will pull those hearts down better than anything else in my hands.

Conclusion. According to my mind, intravenous therapy has proven its value as a prominent factor which mush be taken into consideration when deciding upon a method of treatment. It is a scientific direct, accurate and dependable therapeutic measure.

The use of the Luer syringe has replaced the once lauded gravity method and has been the means whereby of illustrating that accurately and scientifically prepared solutions, in more concentrated forms, in smaller volume are the outstanding important factor in achieving successful results in intravenous therapy.

SOME CASE REPORTS RODENT ULCER, LYMPHOSARCOMA, CARCINOMA

L. C. KUYRKENDALL, M.D.
McALESTER

My tribe (Eye, Ear, Nose and Throat men) being in the minority in this Society, I was at a loss as to what kind of paper to prepare that would be of interest to the greatest number. I thought possibly of selecting a subject in my line wherein I might give you something deep and intricate, but dismissed it for fear I might bore you and you think I was trying to show you how smart I really am. I realize you know practically as much about eye, ear, nose and throat as I, but possibly do not do as much or come in contact with as much of it as we who are doing that work exclusively, consequently, this paper deals with three cases, either of which any of you might have in your practice. I am not reporting these cases because of anything unusual I did, but for your discussion, and that I may learn of your experiences with like or similar conditions. I invite free and frank discussion.

One case recovered; the other two did not.

CASE NO. 1

Mrs. J. A. B., age 40, married, housewife. On February 16, 1927, Dr. J. C. Schlicht called me to see the above named lady.

Present Complaint. About two weeks ago noticed a small "pimple" on her tongue which was near the median line but more on the left than right side. Her throat got sore that evening. The next day the "pimple" had turned black and was gradually spreading out and getting larger around with extreme pain and tenderness upon swallowing or eating, the pain being practically entirely confined to the tongue.

The pain gradually increased until patient is now (two weeks later) unable to swallow anything because of the pain in her tongue and throat. She complains of her jaw being stiff and the tongue so thick that speech is difficult. She has no other symptoms.

Past and Family History. Is negative except for an attack of rheumatism eight months ago in both lower extremities only. She has been taking treatment for this and is better, but is compelled to use one crutch in order to get around.

Examination. The patient is a very slender woman, weighing approximately 100 pounds. She has an anxious expression of the face and evidence of extreme pain and is constantly wiping saliva and expectorating. Temperature 99, pulse 96. The skin of face is very dry and scaly, same is true of scalp. The cervical glands, anterior and posterior, both sides, are palpable. There is no enlargement or swelling of neck. The breath is very offensive, and the patient opens the mouth with difficulty. Eyes, ears and nose normal. There is in the median line of the tongue, but extending more to the right than left side, a flat greyish-white necrotic elevation about 5 mm. above the surface of the tongue and about 25 mm. in diameter. The anterior edge of the elevation is free and pus is seen exuding from beneath. Upon raising this mass from the tongue it appears to be six or eight mm. in thickness and attached only at the posterior aspect. The pus is yellowish in color, serosanguinous in nature and very offensive. When this pus is wiped away there appears quite an excavation with the floor very irregular, showing numerous elevations of granulation tissue.

I used some hydrogen peroxide to clean the ulcer and applied some 20 per cent argyrol solution to it. I did not wish to do anything except in a palliative way until I could get the pathologist out to see her.

February 17, 1927. This redundent necrotic tissue was cut away, smears and cultures made and tissue examined as per report. After wiping all pus out of the cavity, I applied pure chromic acid to the base and edges of the ulcer.

Dr. Schlicht visited her each day and reported favorable progress in the case. On February 26, 1927, Dr. Schlicht reported the excavation had entirely filled in and that the patient was doing her own work about the house and in the yard. Still con-

*Read before the Southeast Oklahoma Medical Association, at Atoka, December 12, 1928.

tinues to use a mouth wash of potassium chlorate and occasionlly some hydrogen peroxide.

February 28, 1927, came to the office and I find the ulcer entirely healed and filled out.

Pathologist's Report February 28, 1927. Urine examination, negative.

Laboratory Report. Patient Mrs. J. A. B. Dr. Kuyrkendall. February 18, 1927. Specimen of smears from tongue. Diagnosis and findings: dark field negative, smear with India ink, negative; cultures; no growth on agar-agar. Culture on blood media; positive Gram's positive cocci which are a form of streptococci.—W. J. DELL.

Tissue Report. Patient, Mrs. J. A. B. Dr. Kuyrkendall. Date, February 18, 1927 Tissue from tongue, color greyish. Consistency firm. Dimensions, 2x6x8 mm. Gross pathology and anatomy; grossly, this specimen consists of a flat-like mass of tissue, showing papillae of the tongue on one surface, while the reverse side shows a hemorrhagic irregular tissue. Microscopical pathology and histology. Sections from this specimen shows almost complete destruction of the epithelial layer, a marked round cell infiltration with inflammatory changes. From this tissue, I have made several slides and am unable to find any evidence of malignant change. There is every evidence of a marked inflammatory change, but no evidence of a classified tumor of any type.

Diagnosis. Inflammatory changes in tissue from tongue.

J. L. LATTIMORE, M.D.

Diagnosis. Rodent ulcer of tongue, streptococcic in origin.

CASE NO. 2.

J. L. S., age 64, farmer-stockman. This man came to see me April 26, 1927, because of his eyes. I have seen "freaks" in the side-shows but never have I seen as grotesque character as this man. His wife (age 22) led and supported him into my office as he was unable to see his way around.

Present Complaint. Up until about two weeks ago he was able to see his way around and could see well how to write and read. Since that time he has not been able to see distinctly. At present can only tell daylight from dark. Says his eyes water so much he thinks that interferes with his vision. Complains of a "scum" over the eyes. The protruding of the eyes is of recent origin, neither he nor his wife being able to recall just when this started.

About 18 months ago noticed the gland (parotid) in front of right ear was swollen —was not tender or sore. Gradually all of the glands of the head, neck and face began to swell until today each gland is greatly enlarged. Says the axillary and inguinal glands are also swollen. He does not know how much he has lost in weight, but has lost a great deal, and his appetite is poor.

During the last 18 months at different times, he has been under the care of the following physicians: Drs. L. J. George, Stuart, Oklahoma, T. H. McCarley, C. M. Pearce and C. J. Brunson of McAlester.

He says he took four "shots" from Dr. Brunson, but that they did not do him any good.

(Later) I am informed the patient had a four-plus positive Wassermann, and was informed by Dr. Pearce he would either take treatment for his condition or go to jail. He was trying to get the County to treat him free, while he was by no means indigent.

Examination. The orbital contents on the right side are protruding from the cavity and are about the size of a tennis ball. The left is slightly smaller. The corneae are dry, due to the lids not closing. The conjunctiva is inflamed and thickened with the blood vessels engorged. Lachrymation is pronounced. He is able to make out hand movements only at six inches. The ophthalmascope shows an optic atrophy on both sides with the blood vessels distended and very tortuous.

There are two lymphatic glands over the frontal bone and extending outward and backward over the temporal bone that have the appearance and feel of a "mammoth Georgia goober" having been placed under the skin. This is on both sides and are exactly alike. From the lower edge of the glands on either side and extending downward there is similar enlargement in direct proportion to the size of the glands involved. These extend under the chin forming a collar so that his head has the appearance of a very fat Poland China hog. The swelling did not intefere with swallowing or eating.

The axillary glands on both sides are as large as hens eggs. The epitrochlear glands are enlarged and feel like a large "buck-shot."

The inguinal glands are as large as pigeon eggs and are very prominent, due to the emaciated condition of this man.

The mental condition is very poor, consequently it is hard to elicit information or treat him.

He refuses to give his family or personal history. The present wife is his second and he her third husband.

On may 7, 1927, I obtained a specimen from the parotid gland on the right side and sent it to the pathologist whose report was received on May 9, 1927, and was as follows:

May 8, 1927. Specimen of glandular tissue 10 mm. by 6 mm. by 8 mm.

There is marked infiltration of tissue with large round cells.

Diagnosis—lymphosarcoma.

I then advised him to take a series of x-ray exposures, and he was referred to Dr. J. C. Johnston.

He took a treatment on May 9, 1927. A few days later came in for another, but as it was not time for his treatment, and in order to satisfy him Dr. Johnston gave him a treatment with the high frequency. I am informed by Dr. Johnston he did not again return for treatment.

I did not again see him until about five weeks later when a patient in Albert Pike Hospital and under Dr. McCarley's care for diarrhoea. At that time the orbital contents were down to normal and the glands on the forehead were not visible (his exposure had been over this area alone) and he claimed to be able to see very good, in that he said he could see me standing at the foot of his bed.

I did not again see this man, but learned he died in August, 1927.

CASE NO. 3.

Mrs. W. F. E., age 34, married, housewife. This lady first came to see me on February 2, 1928, being referred by Dr. J. A. Eubanks of Indianola, because of a persistent sore throat.

Present Complaint. For the last year has had more or less persistent sore throat and cough, there being times when she was entirely free while at others both were rather severe, but would usually subside in a few days under ordinary home remedies. The last two weeks the throat had been very sore and cough pronounced. Has been under Dr. J. A. Eubanks' care during that time. Says it is very painful to swallow and feels like there is a lump in the throat that will neither come up or go down. The cough is worse when lying down and feels like it is cutting her throat each time she coughs. Thinks her tonsils are the sole cause of her trouble.

Family History. Measles, mumps and whooping cough in childhood. In 1922 had an abortion and was in the hospital for a week. In 1925 had left breast amputated at Mayo's. Says Drs. Watson and Pemberton of McAlester, wished to do a radical operation on her breast, having made a diagnosis of malignancy, but that some friends advised her to go to Mayo's, which she did. They amputated the breast under local anaesthetic and told her it was not malignant (patient's statement). Had had no further trouble until about one year ago as above noted. Is the mother of seven living, healthy children. Is between four and five months pregnant at present time.

Father died at 61 of pneumonia, mother at 57 from appendicitis, two brothers living and in good health, three sisters living and in good health. Husband living and in good health.

Examination. The woman has an anxious expression and is compelled to swallow often. With the act of deglutition she grabs her throat on either side with her hands and shows by facial expression intense pain. Immediately afterwards she has a fit of coughing which lasts several seconds. She does not raise any mucus when she coughs, but as soon as the coughing stops she tries to clear her throat, but the mucus is ropy, thick and very tenaceous.

The eyes and ears are normal She has a chronic catarrhal rhinitis of both sides. The anterior and posterior cervical glands are easily palpable.

The tongue is heavily "coated" and the breath is very foul. The faucial tonsils are atrophied and there is no evidence of any disturbance or pus in them. The teeth and gums are clean and in good condition

Using the laryngeal mirror a mass about 18 mm. in diameter is seen in the pharynx attached to the pharyngeal wall opposite the level of the epiglottis. This mass is round and has a large basal attachment and is not movable. It is pearly grey in color and shows numerous blood vessels coursing across it.

The axillary lmyph glands are only slightly enlarged.

She then visited Dr. J. A. Munn to consult him relative to an anesthetic for the purpose of obtaining a specimen of this growth for examination, she would not submit without a general anesthetic. Dr. Munn reported involvement of each lung and advised a stay of 48 hours in hospital before an anesthetic was given her so that the routine laboratory tests might be run and he be able to examine her after that period of rest; she would not go to the hospital. I next saw her on February 24, 1928 (seventeen days later). She was not improved and said that she felt worse than on her first visit. An examination of her throat showed no change except of the mass in the lower pharynx which instead of being round had changed to crescent in shape. She looked as though she had lost some weight in the meantime and was very tired. Local applications were made to this mass and she was placed on liquid diet. She then visited me as follows: March 9, 10, 11, 12, 16, 17, 19, 20, 21, 23, 30, and April 10, 18, gradually getting weaker and the mass getting slightly larger and the inflammatory changes gradually extending upward and involving the tonsils, pillars, soft and hard palate as well as the gums and tongue. At no time did this tissue ever bleed but was covered with a milky white exudate and was very hard to wipe away. On April 18, her condition had become such that she could hardly walk from weakness and exhaustion so was placed in the Albert Pike Hospital.

For about one month before entering the hospital her pain had been so intense she was compelled to eat aspirin tablets in order to swallow water or take her nourishment.

I had her using different mouth washes and taking K. I. on suspicion although the Wassermann was negative

Within thirty minutes after she entered the hospital she had to take 5 grains of aspirin, because of the pain Her temperature was 99, pulse 86, and respirations 20.

Dr. Munn took charge of the general care while I devoted my time and attention to the throat only.

Urine examination April 20, showed nothing out of the ordinary. Blood was haemoglobin 78, leucocytes 6,500, poly's 62 large, lymphocytes 7 small, lymphocytes 29, eosinophiles 1 1-2, basophiles 1-2, other cells none.

She was then in the hospital until April 27, 1928, at which time she was apparently slightly improved and was allowed to go home. Between April 18, and April 27, her temperature ranged from 98 1-5 to of 100 2-5, respiration from 18 to 28. She was given aspirin, a cough mixture containing terpin hydrate, a mouth wash, Hinkle pills, vericolate tablets, sodi bicarbonate, castor oil and codeine sulph.

This lady again entered Albert Pike Hospital on May 3, 1928, with a temperature of 100 2-5, pulse 122 and respirations 38. Four hours later the reading was 100-110-24.

On May 4, 1928, urine was as follows: acid, sp. gr. 1018, albumen x, no sugar, acetone x, diacetic acid x, no bile, indican, bacteria, crystals or casts, pus 3 per field, blood 5 per field.

May 9, 1928, Sp. gr. 1021, albumen xxx, acetone xx, diacetic acid xxx, pus 20 per field, blood 30 per field, and 2 hyaline casts per field.

Examination on May 7, 1928, revealed the condition of her mouth and throat worse than when allowed to go home on April 27. She gradually got weaker and weaker with greater inability to open her mouth and more intense pain. The entire laryngo-pharynx and oro-pharynx were involved in the process, including tonsils, soft palate and base of tongue as well as gums. She was confined on May 8, 1928, at 5:30 A. M., giving birth to a girl weighing 3 pounds and 6 ounces.

Her temperature ranged from 103 at 9 P. M. on May 10, 1928, to 96 4-5 at 8 A. M. on May 6, 1928, the pulse ranging from 100 to 150.

Toward the last it was necessary to keep her constantly under morphine in order to keep her comfortable at all, that with local applications in the mouth and throat with her using a mouth wash was the only medication.

She died at 5.45 A. M., May 16, 1928.

Diagnosis. Carcinoma, pharynx complicated by pulmonary Tb. and pregnancy with confinement.

I have left out all reference to the treatment as administered by Dr. J. C. Johnston and will ask that he and Dr. J. A. Munn open the discussion on this case.

CASE OF SPIRILLOSIS*
(Rat Bite Fever)

JOHN S. PINE, M.D.
OKLAHOMA CITY

Family History. May Higgins, girl age ten years, weight 50 1-2 pounds, previous health good; parents living, in good health. No incidents in family history affecting the present case.

History of Present Illness. Child was bitten by a rat on the end of third finger of the right hand on August 31, 1928. Mother applied mercurochrome and the wound healed promptly. About September 10, child began to complain of illness. About September 12, parents observed erythematous and purplish macules scattered over the trunk, limbs and face. Child was brought to my office on September 13.

Examination. September 13. Multiple erythematous and bluish-red macules over entire body were noted. Axillary glands are enlarged and on right side they are tender and sore. No red streaks connecting the bite with the lympth glands. Child complained of aching and pain in the right arm and legs. Appears tired, listless and has loss of appetite. Pulse is 120 and temperature 103. Tongue has a yellowish-brown coating; bowels are constipated. Skin moist with perspiration and kidney action scant and highly colored. There is a beginning atrophy of entire muscle structure of the right arm. I solicited Dr. E. S. Lain's assistance to make a diagnosis on account of the peculiar condition of the skin, but it seemed new to him. Diagnosis not made. It resembled relapsing fever, septicemia, bubonic plague.

Relapsing fever eliminated by new symptoms of atrophy of right arm and condition and appearance of skin, this in septicemia; lymph glands not general, only axillary; also skin symptoms.

Bubonic plague—onset sudden; white incubation of this was two weeks; petechial rash; this large macular bluish-red from 1 to 10 centimeters in diameter; respiratory symptoms in this case negative.

Symptoms. September 18. Blotches had faded though the skin over entire body was dry and itching. Feet and hands were swollen; temperature was normal; pulse 102. Mother reports rise of temperature at night. Child appears to be much depressed and losing strength.

September 28. Lymph glands slightly smaller; are not so tender; size of arm has probably gained, though is not using it. Skin is still dry with superficial ulcers over feet and legs; still has marked degree of malaise; is constipated; has pain in the legs and feet with evening rise of temperature. I now prescribed a bitter tonic with laxative.

October 13. About once a week she would have two or three days of sharp rise of temperature which would disappear following a heavy sweat. Child was presented at the Skin Clinic of the State Dermatological Association held at the State University Medical School. At this time, the skin was very dry with branny exfoliation over entire body; the hands and soles have a horny, fissured condition with thick, dry scales; child was still pale and sallow; has evening rise of temperature followed by sweats; she still complains of pain in the lower limbs; is weak, appetite is irregular, though bowels not so obstinate. After an examination by Dr. Richard L. Sutton of Kansas City, he at once made a diagnosis of "spirillosis" or rat-bite fever and advised administration of neo-arsephenamine which he reported had been found to be specific for such infections. One dose usually sufficient. Laboratory at University Hospital secured sample of her blood for test, but found they did not have the required stains to find the spirochaeta morsus muris, viz: Giemsa's stain or Burri's India ink. And the dark field would only likely detect during one of the relapses. Child returned home, and on October 15, 2 grams of neo-arsephenamine were given intra-muscularly; also a bitter tonic consisting of cascara, nux vomica and comp. Tr. gention and essence cariod prescribed. For two days following administration of neo-arsephanamine, child complained of some slight nausea though the temperature began to subside within a few hours. Marked improvement in her general condition was plainly observed by the parents.

October 27. Examination shows a marked improvement in every respect, viz: appetite is normally strong, depression has disappeared, child has become vivacious. Branny exfoliation of the body has almost disappeared excepting over palms and soles where fissuring still appears where the horny epidermis is thicker. All pains and discomfort in the muscles and joints have disappeared. Atrophy in right arm is now not perceptible. Briefly, immediately after the administration of neo-

arsephenamine improvement began and has continued uninterruptedly. Soothing cold creams were now prescribed to aid in restoring the skin to its normal elasticity and softness.

November 4. Expoliation of hands and feet has disappeared and deep fissures healed. Child now able to wear her shoes, and appears normal again.

PNEUMOCOCCUS MENINGITIS

Joseph Harkavy, New York (Journal A. M. A., Feb. 25, 1928), reports the case of a woman, aged 57, who recovered from pneumococcus meningitis with serum therapy. He believes that from a survey of the literature it is difficult to state definitely that any one method of treatment is the method par excellence, nor does the experience acquired in one case justify any broad generalization. Yet his own clinical observations and those of others would lead one to the following conclusions: The early diagnosis and the identification of the invading organisms is of supreme importance. Specific serum therapy employed should be definitely potent and should be promptly instituted. The serum should reach all foci of infection in the subarachnoid space. Where adhesions are suspected it should be administered intracisternally as well as intraspinally. Drainage of the cerebrospinal fluid by both routes is an essential aid. During the course of illness the following features of note presented themselves: Sterilization of the cerebrospinal fluid after the first injection of Felton's serum. Development of a temporary block in the lumbar region probably due to adhesions, resulting in a dry tap. Reinfection characterized by a rise in temperature and by the recovery of pneumococcus type 1 from the cisternal fluid. Introduction of serum intracisternally with prompt sterilization of the cerebrospinal fluid. Cultures from the subsequent specimens of fluid obtained by daily lumbar puncture did not yield organisms. Occurrence of serum sickness on the fourteenth day of the illness. Negative results of two blood cultures taken during the course of the illness.

MEDICAL AND PHARMACEUTICAL CO-OPERATION

Perhaps one of the outstanding reasons for the progress in he scientific development of new products has been the spirit of cooperation which has existed between the medical profession and the pharmaceutical industry.

By this close cooperation medical science has contributed to pharmaceutical progress and the manufacturing pharmacists of the country in turn have made a definite contribution toward the development of new medicinal products.

On Wednesday, December 5, the officials and members of the medical, pharmaceutical and allied professions of Lafayette, Indiana, were addressed by Dr. Charles E. Vanderkleed, Chairman of the Contract Committee, of the American Pharmaceutical Manufacturers' Association.

The subject of Dr. Vanderkleed's address was "Improvement in the Quality of American Drug Products Due to Cooperation in the Industry." It is interesting to see the representatives of the several allied professions making arrangements for a periodical study of mutual interests of professional nature with a view to increasing mutual usefulness.

It is only through medical and pharmaceutical cooperation that the greatest advances can be made in conquering disease and improving the health of the American people.

A NEW MEDIUM FOR GALL BLADDER RADIOGRAPHY

Tetraiodophenolphthalein in colloidal suspension is the latest development for visualization of the gall bladder.. The use of this medium was described by Dr. Bernard Fantus in the J. A. M. A. of July 16, 1927.

As the result of subsequent research, colloidal tetraiodophenolphthalein is now available in a form stable toward the gastric juice and readily absorbable from the intestine. The dose containing grams of dye is given in a glass of water. Experiments covering a long period have shown that tetraiodophenolphthalein administered in this colloidal form, normally gives a distinct cholecystogram within twelve hours. It is claimed that the possibility of non-visualization is reduced to a minimum and that nausea, laxative action, or other discomforts are seldom encountered. In this new colloidal form, the chemical will be known as Chole-cysto-col and will be marketed by the Abbott Laboratories, North Chicago, Illinois.

CIRCUMSTANCES THAT INFLUENCE THE OBTAINING OF NECROPSIES

E. T. Bell, Minneapolis (Journal A. M. A., March 24, 1927, reports that during 1927, 1,353 necropsies were performed by the department of pathology of the University of Minnesota. With the deduction of 123 stillbirths, this represents 19 per cent of the deaths in Minneapolis for that year. The most important factor in increasing the number of postmortems is to get physicians deeply interested. This can be accomplished by a competent pathologist who is familiar with the problems of clinical diagnosis and able to teach. No postmortem service will be successful if it is in charge of a poorly trained pathologist. The administrative agencies of the hospitals can secure a fair percentage of postmortems if they really try to do so. Public sentiment in favor of necropsies can be built up in a community if a majority of the physicians cooperate. If undertakers are given helpful and considerate treatment, the great majority will not object to postmortem examinations. The sex of the deceased does not affect the securing of a necropsy up to the age of 30 years; but after this age it is somewhat easier to obtain permission in men.

CANCER OF ABDOMEN AND PELVIC CAVITIES

The immediate results obtained in the series of cases reported by Isaac Levin, New York (Journal A. M. A., Jan. 28, 1928), indicate that an intraperitoneal insertion of capillaries of radon can be performed in the course of an exploratory laparotomy, or in the course of an exploratory laparotomy plus palliative surgery of any type, without adding to the hazzard of the operation and at the same time causing, in a number of cases, a shrinkage of the tumor growth and subsequent prolongation of life and comfort.

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Articles sent this Journal for publication and all those read at the annual meetings of the State Association are the sole property of this Journal. The Journal relies on each individual contributor's strict adherence to this well-known rule of medical journalism. In the event an article sent this Journal for publication is published before appearance in the Journal, the manuscript will be returned to the writer.

Failure to receive The Journal should call for immediate notification of the editor, Barnes Building, Muskogee, Oklahoma.

Local news of possible interest to the medical profession, notes on removals, changes in address, births, deaths and weddings will be gratefully received.

Advertising of articles, drugs or compounds unapproved by the Council on Pharmacy of the A. M. A., will not be accepted.

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EDITORIAL

THE COST OF MEDICAL CARE

This is a message to some of the doctors in Oklahoma, and it is an extremely important one. The American Medical Association at this time is mailing a list of more than 25,000 physicians, selected at random, a questionnaire, requesting the furnishing of certain data pertaining to the invested capital involved in physicians' education, intern training, post-graduate courses, office and traveling equipment, office maintenance, medical society affiliations, library maintenance and medical licensure fees.

This is a survey of the profession, by the profession, and for the benefit of the profession. Every physician is urged to give serious and thoughtful consideration of this matter to the end that complete and reliable data will be given on the several items involved.

You are requested to please, by all means, refrain from ignoring the questionnaire should it reach your hands.

APPENDICITIS: ITS FALLING MORTALITY RATE

Occasionally the reading public is more or less shocked to read of the death, after a short illness, due to appendicitis, of some well known celebrity. Two men*, internationally in the public eye, who have so recently passed in that manner, causes the physician and surgeon to reflect and ponder whether or not these were preventable deaths, for it will be recalled that it was almost an axiom of the late Dr. John B. Murphy that someone was to blame in every case of the appendix going so far as to rupture or to become gangrenous. No doubt this is true, but today the mass of the medical profession may be properly absolved from responsibility in such cases. Not many cases of appendicitis are overlooked by up-to-date physicians today, but despite early and proper diagnosis the human element enters to frustrate and oppose the very best advice, which, if followed, would reduce the case to one of simplicity. In the case of one of the celebrites, at least, it is known that he disregarded advice to undergo an operation and had repeated attacks handled by simple, abortive, but non-curative means. It is well known that no disease of the abdomen is so promptly destructive to life as the case of acute appendicitis, in which, if operation is not promptly and skillfully performed, or the case in which it is reluctantly consented to and performed during the greatest virulency of infection, or when performed too late, in the face of fulminating and rapidly spreading infection. A recent review of acute appendicitis which considers advances in treatment during the last ten years and the possible progress for the ensuing ten years (Bancroft)*, is decidedly optimistic and promises continued improvement. Bancroft's figures on the mortality in acute appendicitis were as follows:

	Cases	Deaths	Mortality Per Ct.
Without adjacent peritoneal reaction	246	2	0.8
With free fluid	127	5	3.9
Acute diffuse peritonitis	72	16	17.8
Abscess	133	5	3.7

Morbidity has concurrently been reduced and there has been a decrease in postopertive hernia and drainage cases due to suturing the peritoneum about the drain and leaving the remainder of the wound wide open but loosely packed with vaselin gauze. Where formerly 15 per cent postoperative hernia occurred in drainage cases, these were reduced to 3 per cent following the procedure above outlined.

Another advance, and all modern surgeons instantly agree that this is a life-saving procedure, is that of the early performance of jejunostomy for either mechanical or paralytic ileus, this being particularly so in paralytic ileus.

A third important step is the very free use of hypertonic saline solution intravenously or subcutaneously in cases where obstruction occurs. It is noted that there has not been much change in the mortality in cases of peritonitis or wide spread abscess.

The factors entering into lessened mortality are:

1. Earlier detection and diagnosis of appendicitis and prompt reference for operation.

2. Improved anesthesia. There is no doubt but what the vomiting which formerly followed the administration of ether was a factor in the disetribution of infection. Now, with ethylene, gas and oxygen, and the various forms of local and regional anesthesia this need not be considered more than a negligible danger.

3. The Levin tube. This small tube, similar to a duodenal tube is easily inserted into the stomach or duodenum, and through this, large quantities of fluids may be introduced and syphoned out. This will almost eliminate vomiting, yet the patient is abundantly supplied with fluids.

4. Postural drainage through the most dependent portion is superior to any other type; the usual tube drainage through the operative incision, soon fails to function.

5. Hypertonic saline in the presence of ileus and repeated transfusions in the presence of sepsis will help the patient overcome toxemia, and should be more generally adopted.

Finally, in summing up the question as to responsibility. This is a divided one. First, the responsibility lies with the attending physician, and regardless of his supposed training or lack of it, he is still responsible and should be able to almost certainly place his finger upon the point of trouble and not only advise but emphatically demand immediate operation. If this is done he may be absolved of responsibility for what may result in a tragic ending.

*Rudolph Valentino.
Tex Rickard.

**Frederic W. Bancroft, M.D., Surgical Clinics of North America, October, 1928.

Editorial Notes - Personal and General

DR. W. T. TILLY, Muskogee, has been confined to his home with illness for some time.

DR. J. E. McDONALD and MISS CATHERINE MITCHELL were married in Tulsa, January 2, 1929.

THE OKLAHOMA DERMATOLOGICAL SOCIETY will meet at the Morningside Hospital January 26, 1929.

DR. and MRS. S. C. SHEPARD, Tulsa, announce the birth of a daughter, Charlotte Margaret, December 28.

DR. O. C. KLASS, Muskogee, who has been ill for some time, is now able to be out and has resumed his practice.

DR. J. L. DAY, Norman, was elected vice president of the Medical Reserve Officers Association meeting in Shawnee in December.

DR. and MRS. CHARLES R. HUME, Anadarko, left December 30, for Los Angeles, California, where they will spend about three months.

Drs. J. M. Byrum and H. G. Campbell, Shawnee, announce the opening of an emergency hospital at St. Oklahoma. Dr. William Fox will be in charge.

CADDO COUNTY MEDICAL SOCIETY met December 14, at Anadarko, and elected the following officers: Drs. E. W. Hawkins, president; C. R. Hume, secretary-treasurer.

TULSA ACADEMY OF MEDICINE had as its guest of honor January 16, Dr. Chas. C. Dennie, Kansas City. After a dinner at the Hotel Mayo, Dr. Dennie read a paper on "Neurosyphilis in Children."

KAY COUNTY MEDICAL SOCIETY elected the following officers for 1929: Drs. J. C. Wagner, Ponca City, president; Merl Clift, Blackwell, vice president; A. C. Kramer, Ponca City, secretary-treasurer; O. H. Gowey, Newkirk, censor.

LINCOLN COUNTY MEDICAL SOCIETY met at Chandler, December 20, and elected the following officers: Drs. J. W. Adams, president; Levi Murray, vice president; J. M. Hancock, secretary; U. E. Nickell, delegate; W. B. Davis, J. S. Rollins and A. M. Marshall, censors.

PUSHMATAHA COUNTY MEDICAL SOCIETY met in Antlers, December 5, and elected the following officers for 1929: Drs. D. W. Connally, president; J. A. Burnett, secretary; E. S. Patterson, delegate; Geo. B. Colby, vice president; H. C. Johnson, John S. Lawson and John Kilpatrick, board of censors.

OTTAWA COUNTY MEDICAL SOCIETY met December 3, at the Miami Baptist Hospital, electing the following officers for 1929: Dr. C. A. McClelland, president; Dr. L. W. Trout, Afton, vice president; Dr. A. M. Cooter, second vice president; Dr. B. F. Ralston, third vice president; Dr. J. W. Craig, secretary-treasurer.

WASHINGTON COUNTY MEDICAL SOCIETY elected the following officers at their meeting December 18: Drs. G. V. Dorsheimer, Dewey, president; B. F. Stover, Bartlesville, vice president; J. W. Athey, Bartlesville, secretary-treasurer. Drs. H. C. Weber and J. V. Athey were selected as delegates to the State Convention.

OKLAHOMA COUNTY MEDICAL SOCIETY elected the following officers December 22: Drs. John F. Kuhn, president; J. T. Martin, vice president; R. L. Murdoch, secretary-treasurer. The following doctors were elected as delegates to the State Convention from Oklahoma county: Drs. A. B. Chase, R. L. Murdoch, J. F. Kuhn, E. S. Ferguson, E. D. McBride, W. W. Rucks, L. J. Moorman, L. J. Starry and E. S. Lain.

TULSA COUNTY MEDICAL SOCIETY was the guest of the staff of the Oklahoma Hospital January 14. Dr. S. C. Venable read a paper on "The Role of the Pathologist in Malarial Infections." Tulsa County installed the following officers for 1929: Dr. C. T. Hendershot, president; J. Franklin Gorrell, President-elect; Henry Browne, vice president; Mary Edna Sippel, secretary-treasurer. The president appointed a committee on Membership, Welfare, Legislative and Public Health, Publicity and Public Relations and Social and Entertainment.

PITTSBURG COUNTY MEDICAL SOCIETY, meeting at McAlester December 21, elected the following officers: J. A. Munn, president; J. A. Barton, vice president; F. L. Watson, secretary; F. J. Baum, censor for three years; O. W. Rice, delegate; Wm. C. Wait, alternate, all of McAlester. Prior to the meeting the attending physicians were the guests of the Albert Pike Hospital, participating in a very enjoyable banquet. The speaker of the evening was Dr. Pat Fite, Muskogee, who gave a lantern slide illustration and talk on "Gall Bladder Visualization."

MUSKOGEE COUNTY MEDICAL SOCIETY elected Drs. R. N. Holcombe, president; S. E. Mitchell, vice president; A. L. Stocks, secretary-treasurer, and I. C. Wolfe, censor. The next meeting will be held at U. S. Veterans' Hospital, February 11. About forty physicians were present. Dr. H. A. Scott reported a case of eclampsia, complicated by an intercurrent attack of erysipelas, and later delivery without incident. Dr. I. C. Wolfe reported a severe case of pyonephrosis complicating pregnancy, apparently temporarily cleared by the use of mercurochrome intravenously. Dr. S. D. Neely presented two clinical cases: one of dermatitis exfoliative and one of psoriasis, both of severe intractable type.

OKMULGEE COUNTY MEDICAL SOCIETY elected for 1929 the following officers: Drs. L. B. Torrence president; J. A. Milroy vice president; M. B. Glismann, secretary, all of Okmulgee. Censor, Dr. J. A. Robinson, Henryetta. The officers announced that for January 18 at 7 P. M. a dinner would be served at the Hotel Belmont after which the members, including many invited from adjacent counties, would hear Dr. John Osborne Polak of Brooklyn, one of the distiguished obstetricians.

SOUTHERN OKLAHOMA MEDICAL ASSOCIATION was organized in December at Duncan. The officers were Drs. A. J. Weedn, president, and J. W. Nieweg, secretary-treasurer. A vice president from each of the ten counties included in the organization was selected as follows: Cotton, Dr. W. C. Alexander, Temple; Stephens, Dr. D. Long, Duncan; Garvin, Dr. Logan Maysville; Grady, Dr. A. B. Leeds, Chickasha; Caddo, Dr. E .W. Hawkins, Anadarko; Jefferson, Dr. W. M. Browning, Waurika; Comanche, Dr. E. B. Dunlap, Lawton; Murray, Dr. W. H. Williamson, Sulphur. Carter county was included but no vice president has yet been selected.

CARTER COUNTY MEDICAL SOCIETY meeting at Ardmore, January 8, elected Drs. J. C. Best, president; T J. Jackson, vice president; F. A. Harrison, secretary-treasurer. Delegates to the State meeting, Drs. W. C. Sain and R. C. Sullivan; alternates, Drs. Walter Hardy and F. P. vonKeller. Dr. J. C. McNeese was appointed censor to succeed Dr. J. W. Shelton. Dr. J. C. McNeese reported cases of influenza and pyletus, discussed by Dr. J. W. Shelton. Dr. T. J. Jackson read a paper on the serum treatment of pneumonia with pneumococcus antigen. Dr. Walter M. Johnson reported cases treated with pneumoquin. Dr. G. E. Johnson reported on observation and result of the use of autogenous serum at Base Hospital 63 A. E. F. Dr. John L. Dorrough, full-time county health officer, was called upon to define the scope of his duties to the County Society. Dr. Dorrough explained that he was not allowed to practice medicine, that his work was 95 to 100 per cent preventative and rural sanitation; that he made charity calls at all times when other work would permit, but that his office was not for the practice of medicine. His greatest problem seemed to be the large number of venereal infections passed to him for treatment.

DR. THOMAS AUGUSTUS BLAYLOCK

Dr. T. A. Blaylock, pioneer Madill physician, died in a Sherman, Texas, hospital January 10, following a car accident several days previous. Dr. Blaylock was apparently improving from pneumonia which followed his injury when his heart, weakened by the strain, gave way.

Dr. Blaylock was born at Springfield, Illinois, November 29, 1871. He received his preliminary education in the common schools. He graduated from the medical department of St. Louis University in May, 1902. His state certificate was issued to him in 1904.

Dr. Blaylock is survived by his wife and one son, two sisters and a brother.

Dr. Blaylock was a Rotarian, Odd Fellow, Mason and Shriner.

TUBERCULOSIS

Edited By
L. J. Moorman, M.D. and Floyd Moorman, M.D
912 Medical Arts Bldg., Oklahoma City

What is Clinical Tuberculosis? F. M. Pottenger, M. D., Am. Rev. of Tb., November, 1928.

Acute infection such as measles, whooping cough, diphtheria and small pox, as a rule, give only one phase of activity during the life of an individual. The causative microorganism enters the body, produces an infection which stimulates the immunity mechanism of the host and the conflict is ended. If the immunity mechanism is competent, the casuative microorganism is destroyed, the individual is victor, and except in rare instances, he is thereafter protected against further disease caused by that particular microorganism.

Tuberculosis, unlike acute infections, is caused by a germ which is protected against the defensive forces of the organism by a waxy envelope, but also permeates its body, thereby making it very resistant to both humoral and cellular defense on the part of the host. It becomes buried and incarcerated in the tissues instead of being destroyed; consequently, once infected may mean, and probably does mean, in most instances, always infected. Always infected, however, this must not be confused with the idea of always suffering from tuberculosis, for the two conditions are entirely different.

The phenomena attendant upon an acute infection are those of (1) reception of the causative germs, (2) their multiplication, (3) stimulation of the immunity mechanism of the host, and (4) the death or recovery of the host with a resultant lasting immunity if the immunity response is competent to cope with the infection. The phenomena attendant upon a tuberculous disease are different. Tuberculosis is not a single episode of infection, bodily reaction, immunity and healing, or failure of immunity and death, but a succession of inoculations met by a succession of responses until the clinical healing of death occurs. These episodes may be repeated at frequent intervals or be stretched out over months and years. One important cause of difference is the inability of the host to rid himself of the infecting tubercle bacilli, and to develop anything more than a relative immunity. Another factor is that the competence of this immunity fluctuates.

A few children die of their first infection before specific resistance has been established, but the majority survive this and may secure a permanent healing.

Tuberculosis as we meet it most commonly, and particularly in the adult, is a succession of the episodes which make up the picture of acute infection, plus the particular modifications which are injected by the fact that the infection takes place in a host, whose tissues already have been endowed with the power to specifically defend him against the invasion of tubercle bacilli.

Active clinical tuberculosis is likely to be a succession of reinoculations with immunity responses. The exception to this is when the disease heals at once after reinoculation occurs, which is the thing most desired but not regularly attained.

The prognosis in tuberculosis is bound up closely with these reinoculations. The frequency with which they occur, the numbers and virulence of the bacilli causing them, and the resistance of the patient at the time the reinoculation takes place are three factors which largely determine the course of the disease. The immunity mechanism is set in motion by an infection produced by living tubercle bacilli and to a lesser degree by dead bacilli and possibly to minimal extent, by tuberculo-protein; but for an efficient protective response living bacilli are necessary for the primary inoculation. After the mechanism has been set in motion and immunity has once been established then either living bacilli, dead bacilli or tuberculo-protein will stimulate it further and increase its efficiency.

Immunes, as compared with the noninfected, show the following important phenomena: (1) a quickening and increased power to destroy invading tubercle bacilli, (2) an immediate inflammatory response which tends to confine the invading bacilli at the point where they lodge in the tissues, and (3) a secondary inflammatory and exudative response in unhealed foci elsewhere in the body, produced by the tuberculo-protein which results from the destruction of bacilli at the site of attempted implantation, escaping from the focus and circulating in the blood streams, and which, coming in contact with the cells in unhealed tubercles, cause a defensive inflammatory reaction to be thrown about them. This defensive force destroys many bacilli and exerts a general restraining action on others, preventing them from spreading in case they should get beyond the walls which have confined them; and further stimulates the healing of tubercles.

We can observe in the course of clinical tuberculosis, either on physical examination, or by the x-ray, if our plates are satisfactory in quality and are taken sufficiently often, that many reinoculations occur without implantation resulting. In such instances of abortive infection the bacilli are destroyed.

With the specific inflamatory response well established it is probable, judging from our clinical observation, that small and even large reinoculating doses of bacilli rarely produce permanent disease. They are opposed by immediate inflamatory response on the part of the local cells, and after a time, are destroyed or walled in and rendered inocuous. In the process, however, they serve the host well by building up his immunity and also by causing secondary reactions in unhealed foci elsewhere in the body, thus favoring their healing by fibrosis or resolution.

The power to resist the process of tubercle bacilli through the tissues, which is conferred upon the cells of the host by a prior infection with tubercle bacilli, is one of the most important facts in the specific protective mechanism.

That all tissues of the body have conferred upon them, as a result of a prior tuberculosis infection, a power to react to tuberculo-protein when they come in intimate contact with it, and that this quality is possessed the strongest by those cells which make up the intimate structure of the tubercle, are facts of primary importance in ridding the host of tuberculous infection. This affinity between bacillary protein and the highly sensitized cells in the tubercle is so strong that a reaction occurs whenever they come in contact. No effect is noted in other cells of the body unless the bacillary substance is introduced directly into the tissues as by intracutaneous or subcutaneous injection, in which case it is held in close contact with the cells for some time.

Only large and repeated reinoculations, which depress or overcome the patient's immunity, for

the time being, are responsible for such a calamity. This we see in the rapid spread that occurs during the last few weeks of life. We also see it in instances in which the patient's general resistance is very low. As long as the patient's immunity is relatively high "autotuberculin" reactions are curative and not harmful.

Parenteral Quinine Therapy With Observations on its Effect in Pulmonary Tuberculosis. Harland F. Newton and Kurt Heine, American Review of Tuberculosis, November, 1928.

Transpulmin a sterile solution of basic quinine and camphor in other oils, each cc. containing 0.03 gm, aubydrous basic quinine and 0.025 gm. of camphor was used in forty selected cases of pulmonary tuberculosis, uncomplicated by recognizable tuberculous faci elsewhere in the body.

All patients had remained at rest in bed for at least one to two months. During this time routine sanatorium treatment was carried out, so that each patient had established a clinical "level" of improvement.

Transpulmin was then given intragluteally 2 cc. daily for three to five weeks. None of the patients experienced any local pain or irritation from the injections.

In twenty-eight patients, all chiefly productive cases of pulmonary tuberculosis, the drug seemed to produce favorable effects. The maximum temperature showed a steady decline of 2 degrees Fahrenheit in 12 to 14 days, the patients often becoming afebrile. Irritating unproductive cough present in more than two-thirds of the cases, was relieved in 13 to 16 days. In the patients with productive cough for five to eight days after treatment the sputum increased slightly, and then showed a steady decline. At the end of four to five weeks there was no appreciaable expectoration, and all but two patients were "bacillus-free." None lost weight, and the average gain was 7.5 pounds. There was a decrease of physical signs on frequent examination of the chest.

Roentgen examination, at the end of five weeks, also showed improvement proportional to the severity of the preexisting tuberculosis.

The remaining 12 patients showed a productive cirrhatic type of lesion, with slight elevation of temperature and daily expectoration of about 15 cc. Here, treatment with old tuberculin, was given with transpulmin, after the latter alone, for three weeks, had shown little or no effect. The tuberculin was given every fourth day, intracutaneously, beginning with 0.2-0.4 cc. of a 1-0.000,01 solution, and increasing the amount and strength of the tuberculin with injections. Transpulmin treatment was the same 2 cc. daily intragluteally. Coincidently, tuberculin therapy alone was given to twelve patients, all having, as nearly as possible, the same type of pulmonary tuberculosis.

Tuberculin combined with transpulmin definitely caused a more rapid improvement than when tuberculin alone was given. This was shown by an afebrile temperature, the sputum becoming in all cases scanty and "bacilli-free," gain in weight and active signs in the chest diminishing.

Climate in the Treatment of Pulmonary Tuberculosis. James Alexander Miller, American Review of Tuberculosis, November, 1928.

The author cites the opinion of physicians from Hippicrates up to the present time as to climate in the treatment of tuberculosis, and gives the advantages and disadvantages of various sections of the United States, with a summary of results obtained in 1028 cases who received treatment in the North, West, South, Southwest and at home, with the following conclusions:

The similarity of results obtained, both immediately and after the lapse of several years, appears to leave no escape from the conclusion that, at least, where there is a similar basis for the selection of the locality and when this basic is employed by the same physician, practically identical results may be expected in each locality.

The regime of regulated rest and exercise, proper food and open air life, is the fundamental essential in the treatment of tuberculosis. Competent medical advice and supervision are essential. There is no universally ideal climate. For each patient there may well be a most favorable environment, if we are wise enough to find it.

The X-Ray Evidence of Allergy and Clinical Phthsiogenesis. I. Rappaport, M. D., American Review of Tuberculosis, November, 1928

The successful invasion of the pulmonary parenchyma as a result of contact infection brings about a focus-formation, and surrounding it, a perifocal infilteration as a local manifestation of allergy. This is the lesion first revealed on the x-ray plate by Wessler as from 1 cm. to 1 inch in size, its site predilection being the infraclavicular region.

Only about 5 per cent of these initial infiltrations were found behind the clavicle or in the real apices. The initial infiltrations go unnoticed by the patient until the allergic phenomena are local. They are therefore discovered accidently or when looked for in people living together with open contact cases. With slight invasions the allergic phenomena may remain restricted altogether to the place of invasion, the focus healing, perifocal infiltration being absorbed and the patient feeling nothing more than some passing indisposition.

With moderately extensive foci and larger perifocal infiltrations, allergic phenonema become general in the form of toxic shock, rise in temperature, malaise, etc. Several invasions lead to general symptoms not unlike pneumonia.

The Fate of the Tuberculous Cavity. Felix Baum, Sol Mebel and Allen Kane, American Review of Tuberculosis, November, 1928.

The authors say we may differentiate between two types of cavities, one caseous and the other pyoid. They call cavities with a ragged and irregular contour sequestrum cavities and conclude that this type of cavity is more likely to occur in the first allergic stage. The other is called concentric and is formed from lesions of the exudative type, which were ultimately converted into liquifaction necrosis. On the sputum of such cavities we rarely find tubercle bacilli although the sputum may be loaded with elastic fibers.

We are dealing here with typical cold abscesses, in which the tubercle bacilli are destroyed by leucocytes and enzymes. This type of cavity is more likely to be found in the second allergic stage. By the shape of cavities and the thickness of their walls we may be able to determine the allergic stage in which they are formed. The fate of the cavity depends upon the stage of its formation. The kind of tuberculosis resulting in liquifaction necrosis is more readily absorbed. There is a difference between the healing and the repair of a cavity. The latter occurs in the third stage, in which the cavity is collapsed and masked

by thickened pleura. Healing takes place in the first two stages by connective tissue replacing the destroyed parenchyma. It is possible that healing can occur through the regeneration of parenchyma.

Infraclavicular cavities, because of their location and the stage in which they are usually formed, show a strong tendency of spontaneous healing.

Three conditions are essential in the repair of lesions in any organ. These are as follows:

1. The lesion must be aseptic.
2. There must be drainage.
3. The tissues must be in apposition.

Four cases are reported in which cavities disappeared.

UROLOGY and SYPHILOLOGY

Edited by Rex Bolend, B.S., M.D.
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CLIPPINGS
From
THE UROLOGIC AND CUTANEOUS REVIEW

A urethral fistula cannot be closed if a stricture lies in front of it.

That syphilis may be transmitted through the semen is well established.

After forty years of age few patients have perfectly functioning kidneys.

It cannot be depended upon that a diseased kidney is necessarily palpable.

Be suspicious of a pyuria which clears up abruptly. It may be a blocked pyonephrosis.

When you discover albumen in the urine, always find out what medicine the patient has been taking.

Boil all catheters, ureteral and silk woven included, even though their lives are thereby shortened.

The first essential for genito-urinary surgery is to learn to pass instruments gently as well as skillfully.

Warm solutions of an anesthetic are more efficient than cold solutions for anesthetizing the urethra.

Syphilis in medical men, following accidental inoculation, in many instances runs an unusually severe course.

When you have an instrument in the urethra, always know where its tip is, and how much pressure is on the tip.

A severe pain probably referable to a kidney, if following a boil or carbuncle, should arouse suspicion of a perinephritic abscess.

The morphology and grouping of the gonococcus are more to be relied upon than the staining or lack of staining by the Gram method.

Bismuth rarely causes stomatitis, and when it does do so the stomatitis is apt to be light in character and only around bad teeth.

Obstinate ulcers of the bladder may be syphilitic in origin. If local measures fail or there is a suspicious history, make a therapeutic test.

When urethrotomy is indicated—which is seldom—the procedure that gives best drainage is a combined internal and external urethrotomy.

Do not use serum for the Wassermann test if the patient has recently been drinking alcoholics, since they may change a positive into a negative test.

In pyuria, do not jump to the conclusion that the focus is in the bladder or higher up; a primary duty is to eliminate the urethra, prostate and seminal vesicles.

In treating a syphilitic, always bear in mind that what you are doing for him ishis best insurance against paresis, tabes, and other later manifestations.

In the case of sharp bleeding after the use of an easily introduced urethral instrument, examine urethroscopically. You may find a papillomatous growth in the canal.

A vesical irritation in a woman without gross urinary changes points to the need for a careful pelvic examination. In some of these cases a misplaced uterus is the cause.

The time to take out an enlarged prostate is before serious damage has been done to the kidneys. When a constant residual urine of 30 cc. has been established, the time is well at hand.

Inasmuch as the most important factor in the mortality of prostatectomy is renal incompetence, it is obvious that close attention to the renal function is essential if this mortality is to be kept down.

Heart complications follow gonorrheal infections more frequently that we suppose. Gonorrheal cases complaining of precordial pain, palpitation, irregular beat, or dyspnoea should be put to bed and very carefully examined.

"Calculus of the Upper Urinary Tract Treated By New Methods; End Results."—Guy L. Mumner (The Journal of Urology, July, 1928), believes that there is an important causal relationship existing between the presence of ureteral stricture and the formation of calculi in the upper urinary tract. Clinical experience suggests that it is possible for a calculus in the kidney to have as a nucleus a ureteral stone, which has migrated as the result of dilation of the ureter above the stricture. Most renal calculi, however, no doubt arise in the kidney, and their formation is probably influenced by renal stasis caused by ureteral stricture. This, however, is not the whole story, or we would be confronted with a far greater ber of stones than we really are. In treating calculus of the upper urinary tract, the establishment of adequate renal drainage is to be sought chiefly, according to the author, who believes this dictum to be borne out by the end results in seventy-eight cases under his observation since he began this mode of treatment in January, 1927.

"Investigations on the Ureter and Kidney in Pregnancy."—Kamniker (Wien. Klin. Woch., July 5, 1928), at a meeting of the "Geburtshilflich-gynaekologische Gesellschaft" in Vienna, June 12, 1928, demonstrated numerous uretero and pyelograms which showed the changes taking place in the ureters and renal pelvis in pregnancy and the puerperium. Three types of women were observed, those who had no trouble, those who complained of a slight nagging pain in the renal pelvis, and finalily those who presented all the signs of pyelitis of pregnancy. Dilation of the ureter and renal pelvis could be demonstrated. At the lower end of the renal pelvis at the physiological narrowed portion of the ureter was found kinking which took various forms. Similar changes were also found in pyeloscopic observations. The pain in the kidney and ureteral regions, found in so many pregnant women, is apparently caused by the dilatation and kinking of the ureter. The ureteral catheter could be introduced only for 15 to 18 cm. in these pregnant women.

"A Case of Syphilitic Mastoiditis."—R. Gaillard (Ann. des. mal. del' oreille, April, 1927), reports the occurence of a mastoid gumma accompanied by meningitis and paralysis of the seventh cranial nerve. Surgical intervention and complete recession after three injections of neosalvarsan.

ORTHOPAEDIC SURGERY

Edited by Earl D. McBride, M. D.
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Krida, A.: Congenital Dislocation of the Hip; the Effect of Anterior Distortion; A Procedure for its Correction. J. Bone and Joint Surg., 1928, x, 594.

Confining his remarks to the closed reduction of congenital dislocation of the hip in young children, Krida emphasizes the importance of recognizing the anterior distortion in this condition and its effects upon reduction and retention of the head within the acetabulum.

After reviewing the historical aspects of the treatment, he describes in detail a method he has used satisfactorily in nineteen cases with anterversion of the neck. He is of the opinion that distortion is a more frequent cause of failure in permanent reduction than is generally recognized. Therefore, after reduction and the ninety-ninety position for two weeks, he removes the plaster and places the limb in a degree of internal rotation which is necessary to overcome the anterior distortion entirely. Ordinarily, the limb is held in this position for three months and at the end of that time, the internal rotation is corrected by a manual supracondylar osteotomy in which one hand fixes the head of the femur in its original position and the other hand rotates the lower fragment outward until the patella lies in the sagittal plane or somewhat beyond it. Plaster is then applied with the hip in moderate abduction and with slight flexion at the knee. In unilateral cases, this cast is left on for six weeks, and in bilateral cases for a longer time. On its removal, normal activity is resumed gradually.

Isolated Contusions of Bones (Experimental Research) G. Toschi. Chir. D. Org. di movimento, xii, 41, January, 1928.

The author, by means of a bruising apparatus, devised by him and with which the violence of the trauma can be fixed accurately, has produced pure contusions of bone (i.e., not associated with fractures, infractures, fissures or the detachment if even minute fragments) in the middle third on the antero-internal surface of the right tibia of rabbits of the same age and same state of nutrition. In a series of experiments, studying at varying intervals the objective signs and the microscopic and microscopic alterations in the contused right tibia with the non-traumatized left tibia, the author reveals the various clinical factors (pain, redness, ecchymosis, tume faction of soft parts and bone functional disturbances) and the anotomopathological factors (subperiosteal bone changes, etc.) represented by extravasated blood, by oedema, by proliferation and multiplication of formative cells of bone and of fibrous connective tissue even to the formation of haversian architecture, that calcified reproduces exostoses and hyperostoses, and that from the anatomopathologic point of view would be defined as circumscribed traumatic osteoperiostoses.

The experimental researches, illustrated with figures of the various states of the evolution of bone contusions, are followed by considerations regarding the process of subperiosteal ossification and by conclusions which have a certain practical value.

Fracture and Dislocation of the Stermum. Report of Three Cases. Herbert H. Holderman. Ann. Surg., lxxxviii, 252, August, 1928.

This is a rare condition. The ribs usually break first. Direct trauma is the most frequent cause. Blows or compression of chest are most frequent causes. It has been known to occur from muscular action. The most common type is a transverse fracture at the junction of the manubrim with the gladiolus. The prognosis is good, except in the complicated cases. Diagnosis is usually not difficult. The lateral x-ray shows the fracture better than the anteroposterior view. Reduction is accomplished by hyperextension of the head and arms over the end of a table. Open operation is justifiable if manipulation fails. Adhesive strapping and rest in bed is the best treatment. Three cases are reported.

Wakeley, C. P. G.: Sn. Ossifying Chondroma of the Ribs Mistaken for Sarcoma. Brit. J. Surg., 1925, xiii, 175. .

Wakeley reports the case of a man 42 years of age, who, in 1916, sustained a severe contusion of the right thorax and in August, 1923, noticed a smooth lump the size of a walnut one inch above and external to the right nipple. Pain and weakness developed on the inner size of the right forearm with numbness and tingling of the ring and little fingers.

Examination revealed a large, rounded, pulsating tumor of the right thorax which was fixed to the chest wall; slight weakness of the muscles of the right forearm and hand supplied by the lower cord of the brachial plexus; and atrophy of the thenar eminence. The x-ray diagnosis was malignant tumor.

At operation, a lobulated, pearly blue tumor measuring seven by six inches was removed from the fourth rib. On section, definite areas of ossification were found. Microscopic examination showed the tumor to be typical chondroma. When the patient was seen six months after the operation he had completely recovered.

Genu Varum and Genu Valgum Infantum: M. Boehm. Ztschr. f. orthop. Chir. xlix 321, 1928.

There is no doubt that many cases of genu varum or genu valgum are not caused by rickets. However, various theories which have worked out to explain these frequent deformities have not been satisfactory to Dr. Boehm who, with his well known industry and skill, has carefully studied this problem. His studies have led him to the conclusion that the non-rachitic genu varum and valgum represent a regressive rather than a propressive variation of the development of the skeleton of the lower extremities. The normal phylogenetic development shows very distinct declinations of a more or less degenerative character. Static and mechanic forces, weight-bearing and transformation, heretofore considered to be of sole or main value in the development of lateral deformations of the legs, are not of such importance in regard to the primary development, but act only as a secondary force after the natural varying development has induced to characteristic declination. The human leg of the new-born lies in a position of flexion, lateral declination, and outward rotation of the knee joint. Postnatal development during the first five years, as Boehm has observed on many children as well as specimens of cadivers, shows a disappearance of the flexion, a slight medical declination, and a slight inward rotation of the knee. In certain cases, however, variation of the normal development takes place in a progressive rather than a regressive sense, leading eventually to the formation of a genu valgum rather than a genu varum.

Operation of the Habitual Dislocation of the Shoulder Joint: Kirschner (Tuebingen): Zentralbl. f. Chir., lv, 946, 1928.

Kirschner discusses Hoffman's operative method for the repair of the habitual dislocation of the shoulder, which consists in slinging a wire around the humerus and fastening it to the acromion. Kirchner points out that Hoffman's method is but a poor modification of his own method, consisting in slinging a fascial ligament around the head of the humerus without opening the joint. Kirschner has operated on thirteen cases and in only one case recurrence has taken place. Most of these cases were operated on many years ago. Lately Kirschner has pulled the fascial strip through a bone channel just below the head in sagittal direction. He thinks his method is simpler and less dangerous than those methods which open the joint. An absolute guaranty cannot be given by any method, in regard to the avoiding of recurrence.

Ossifying Hematoma: James B. Bullitt. California and West. Med., xxvii, 508, October, 1927.

A boy of eighteen developed a hard swelling in the lower third of his thigh, three weeks after injury in a football game. Roentgenogram showed a lightly calcified mass three and five-tenths by six centimeters in size attached to the femur, but slightly movable. The mass was removed nearly three months after the injury and was found to be made up of bone. Roentgenogram, four months later, showed no recurrence of the growth.

The question arises whether this is a myositis or an ossifying hematoma. The former term does not seem well chosen because, in such cases, the muscle takes no part in the process but rather is passive. The bony growth proceeds in blood clot and goes in between muscle planes, not into the muscle substance. Whether the bone tissue is derived from displaced periosteum or whether it is the result of a traumatic aseptic myositis, is still an unsettled question, with the latest investigations favoring the latter theory. Numerous observations have shown that connective tissue can form bone, as observed in repair of fractures.

This paper includes a very able discussion from an embryologic point of view, on the formation of these growths and the weight of evidence seems to be that the periosteum does not play a necessary part in them.

Stabilization of the Shoulder Joint for Habitual Dislocation. Hans Spitzy. Surg. Gynec. Obstet., xlvi, 256, February, 1928.

Cases operated upon by the author's method recovered complete working capacity and full motion, with no recurrences. The operation consists of exposing the deltoid insertion by a curved incision, detaching same and retracting the muscle upward, then passing strong, double silk around the surgical neck of the humerus and tying in front and suturing and tying the four strands to the coracoid process and its attached biceps tendon. The capsule on the front of the shoulder joint is reefed and sutured over these four strands of silk, thus reenforcing and shortening the capsule at its weak part. The deltoid insertion is sutured in place and the arm is kept at rest for four weeks; then careful exercises are begun.

DR. A. L. SKOOG

—wishes to announce the resumption of consultations for nervous and mental cases after some months of visiting and work in several European clinics. Returning home February, 1929. Out-of-town consultations considered.

Appropriate arrangements in Kansas City for patients requiring confinement.

Twenty-five years' experience limited to study, practice and consultations in the field of neurology and psychiatry.

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Meeting Place, 1929, Oklahoma City.

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